

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8508582	
REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Charles Nelson Amos.			3 21 85			4:50 P.M.	
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		
Male		White	3 27 01		83	# UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Maryland		United States		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD			
10. CITY OR TOWN OF DEATH FAIRSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRSTON GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	
13a. STATE Maryland		13b. COUNTY Harford	13c. CITY OR TOWN Street	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 401 Glasgow Road 21154	
14. FATHER'S NAME James		MIDDLE R.	LAST Amos	15. MOTHER'S MAIDEN NAME Anna		LAST Torbert	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. No -----		17. INFORMANT Marie H. Amos		ADDRESS 401 Glasgow Road Street, MD	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest.</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 min	
7 9289 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Head trauma, blunt</u>						4-1 hr	
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:10 P.M. 3 21 1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2) Pt. found to head injured on concrete floor next to stool.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET Glasgow	CITY OR TOWN Street	COUNTY Harford	STATE Md.
22a. I certify that (I) (this hospital) attended the deceased from show the deceased alive on above (I) will (did not) view the body after death.		22b. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/21/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Randall Crain, Jr.		22e. ADDRESS 721 Wheeler School Rd. Wh. Harford, Md. 21160					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/23/85	23c. NAME OF CEMETERY OR CREMATORIUM Highland Cemetery		23d. LOCATION CITY OR TOWN Street	COUNTY Harford	STATE Md.
24. FUNERAL DIRECTOR NAME John Hartman 600 Main St. Delta Pi		25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE MAR 26 1985 Julie S. Johnson-Anderson					
		ADDRESS					

2028 2028 2028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or (e) 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8508583
1. DECEASED NAME [TYPE OR PRINT] ELIZABETTA MORABITO ARMENI					REG. NO.
2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH 3 DAY 9 YEAR 02	6. AGE [IN YEARS LAST BIRTHDAY] 82 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY] Italy	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD		
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION [IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS] FALLSTON GENERAL HOSPITAL			12a. USUAL OCCUPATION [TYPE OF WORK FOR MOST OF WORKING LIFE] Homemaker	12b. KIND OF BUSINESS OR INDUSTRY MD.
13a. STATE Md.	13b. COUNTY Harford	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4339 Norrisville Rd. 21161	
14. FATHER'S NAME FIRST Savario	MIDDLE 	LAST Morabito	15. MOTHER'S MAIDEN NAME FIRST Rosa	MIDDLE 	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. 212-30-7190	17. INFORMANT	ADDRESS Joseph Armeni 4339 Norrisville Rd. 21161		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) SEPSIS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) STROKE					
DUE TO, OR AS A CONSEQUENCE OF (c) ISCHEMIC HEART DISEASE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). DIPHTERIA					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED [ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2] 1984 to 1985			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from Sept 3/7 1984 to March 7 1985, that (I) (we) last saw the deceased alive on 3/7 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE J. Miller DEGREE					
22d. PHYSICIAN'S NAME [TYPE OR PRINT] PHILLIPS		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3-11-85	23c. NAME OF CEMETERY OR CREMATORIAL Gardens of Faith	23d. LOCATION CITY OR TOWN Balto.	23e. COUNTY Balto.	STATE Md.
24. FUNERAL DIRECTOR NAME John C. Miller Inc.	ADDRESS 6415 Belair Rd.	25a. DATE RECD. BY REGISTRAR MAR 11 1985	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

W.M. C. WILSON 1921

1921

1921

1921

1921

W.M. C. WILSON 1921

1921

BOOKS COLLECTED

1921

1921

1921

091081

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8508584

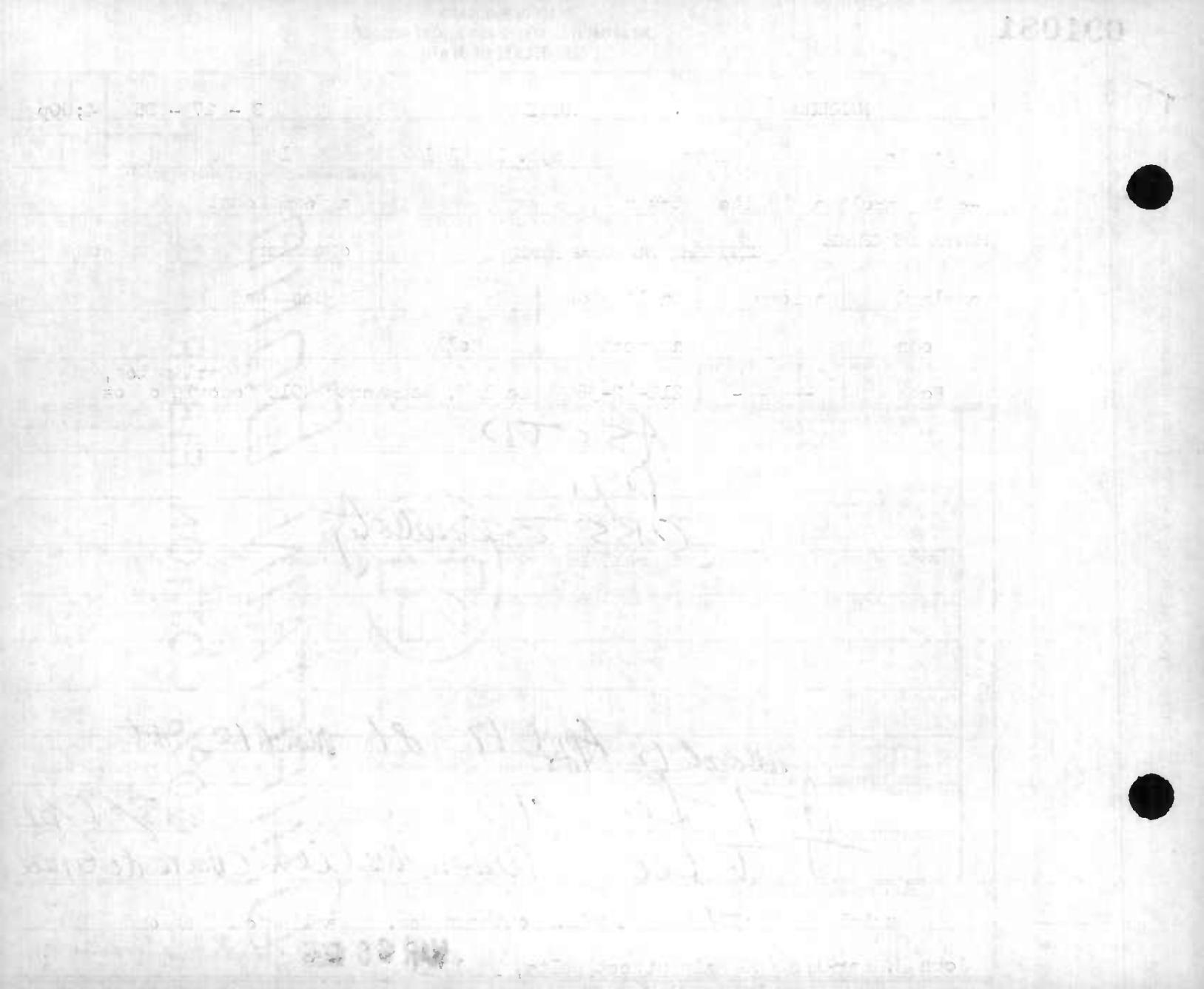
1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
NANNIE V. AUSTIN						3 - 17 - 85				4:00p m			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		MONTH	DAY	YEAR	71	MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
North Carolina		United States		Sept. 15 1913		Harford County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
HAVRE DE GRACE		CITIZENS NURSING HOME				Homemaker		Own Home					
13. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21084			
Maryland		Harford		Darlington		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Hughes Road					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST				
John				Daugherty	Molly								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT		ADDRESS					
No		213-42-3647				Earl F. Daugherty		Darlington, MD 4010 Conowingo Road					
18. CAUSE OF DEATH (Enter only one cause per line for 18, 18a, and 18b) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASODD</u>													
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>DM</u>													
DUE TO, OR AS A CONSEQUENCE OF (b) <u>DM</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CBS assembly</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> ^{at work}		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) examined the deceased from <u>March 2</u> 1985 to <u>March 17</u> 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.													
22b. SIGNATURE <u>J. T. Lee</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>3/18/85</u>			
22d. PHYSICIAN'S NAME <u>J. T. Lee</u>		22e. ADDRESS <u>Dublin, Med Clinic, Havre de Grace</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		3/20/85		Dublin Southern Cem.		Darlington		Harford		MD			
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John H. Harkins		600 Main Street Delta, PA 17320				MAR 26 1985		John Harkins					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death is reported by the hospital or attending physician.

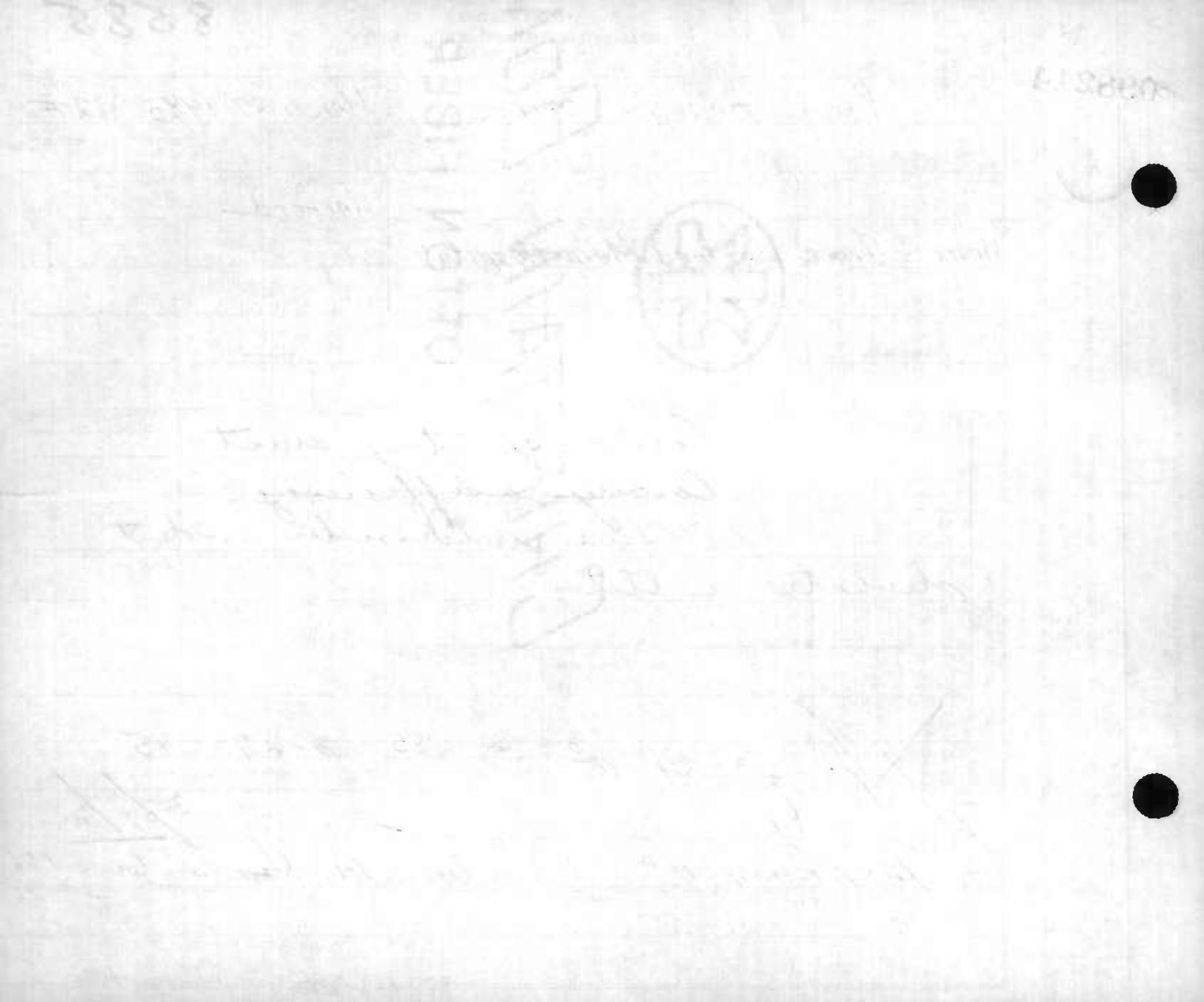
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be delivered for use at the funeral home or cemetery. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified by the hospital or attending physician.

#8, 14, 15, 17, per F.H. 4/11/85 kam STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 850 8585

1 - STATE REGISTRAR		1a. DECEASED NAME (TYPE OR PRINT)		1b. FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOURS	
		Perry Bailey Barbre					March 27, 1985		12 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		February 17, 1910			75 yrs			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 23 HRS MONTHS DAYS HOURS MIN.	
Virginia		USA					Harford			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace		Harford Mem. Hospital					Civil Employee US Gov't.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Maryland		Harford		Aberdeen			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3526 Churchville Rd. / 21001	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S M AIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO N/A			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS	
James James Barbre		Emma Elizabeth UNK Jones					220-07-4577		James Barbre, 635 Edgewood, MD Hornbeam Rd. 2140	
18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. DUE TO, OR AS A CONSEQUENCE OF (b)		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
		Coronary insufficiency								
		Massive cerebrovascular accident								
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		22. dabetes mellitus								
23a. DATE OF OPERATION		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED		23a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		23b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
23c. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH IF EITHER, NOTIFY MEDICAL EXAMINER		23d. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		23e. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)						
23f. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		23g. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		23h. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
23i. I certify that (1) this hospital attended the deceased from 3-27 1985 to 3-27 1985 that (1) (we) lost now the deceased after on 3-27 1985 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.		23j. DEGREE		23k. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23l. DATE SIGNED APR 01 1985				
23m. PHYSICIAN'S NAME (TYPE OR PRINT)		23n. ADDRESS								
H. L. Lanyakow M.D.		318 So. Union Ave. Harford, MD 21078								
23o. BURIAL, CREMATION, REMOVAL (SPECIFY)		23p. DATE		23q. NAME OF CEMETERY OR CREMATORI		23r. LOCATION CITY OR TOWN		23s. COUNTY MD STATE		
Burial		Mar. 29, 1985		Mt. Zion Cemetery		Fountain Green, Harford,				
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Tarring Funeral Home, P.A., Aberdeen, MD, 21001										



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 8 3 8 0

REG NO

1. DECEASED NAME (TYPE OR PRINT)			FIRST EDWIN	MIDDLE SHERIDAN	LAST BARROW	2a DATE OF DEATH MONTH DAY YEAR	2b HOUR 11:20 A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 7, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 77		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bel Air, Md.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.				
10 CITY OR TOWN OF DEATH Forest Hill		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2233 Ady Road		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b KIND OF BUSINESS OR INDUSTRY US-govt.-Ret.				
13a STATE Maryland			13b COUNTY Harford		13c CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 2233 Ady Road 21050	
14 FATHER'S NAME FIRST Preston			MIDDLE —		LAST Barrow		15. MOTHER'S MAIDEN NAME Annie		LAST Robinson	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-03-2599		17 INFORMANT Mrs. Janet L. Wagoner, 2233 Ady Road, Forest Hill		ADDRESS Md. 21050			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3/13/85				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>6/7</u> , 19 <u>83</u> , to <u>3/13</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>3/13/85</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (I) (did not) view the body after death.										
22b SIGNATURE <i>Gary F. Harne</i>		22c DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <u>3/22/85</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gary F. Harne, M. D.			22e. ADDRESS 715 Shamrock Road, Bel Air, Md. 21014							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 25, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Deer Creek Methodist		23d. LOCATION CITY OR TOWN Forest Hill		COUNTY	STATE Harford Md.	
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		ADDRESS Howard K. McComas III, Abingdon, Md. 21009		25a DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE <i>Howard K. McComas III</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN. The
treatment by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed, it should be detached for use on the burial permit and filed with the State Dept. of Health and Mental Hygiene.

IMPORTANT: Item 2 is marked on Item 18 above.

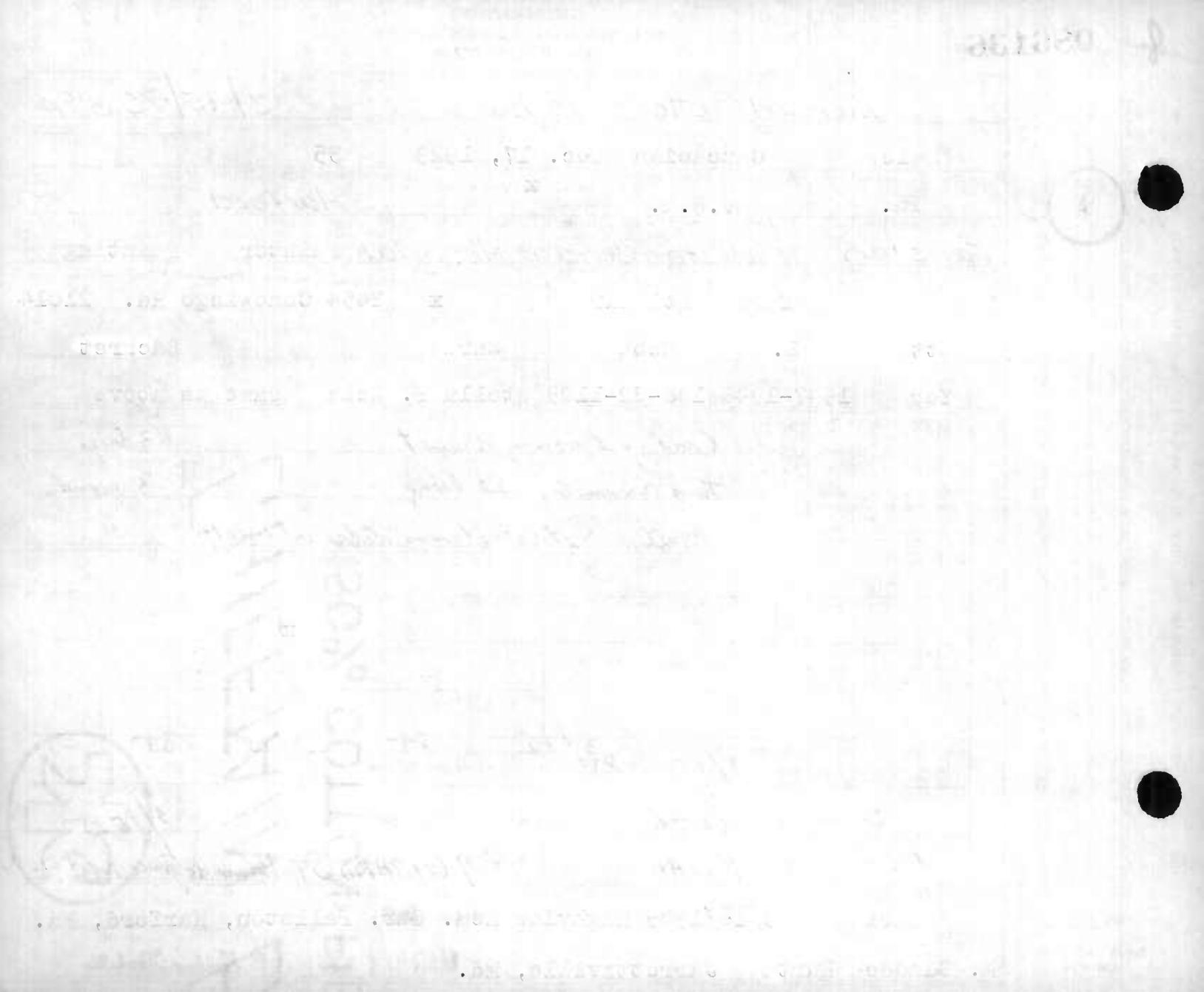
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

RECORDED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

086136 FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8508581

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Richard otto Beba						3/15/85				3:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Caucasian		Dec. 17, 1929		55		YRS		MONTHS DAYS HOURS MIN.	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Pa.		U.S.A.				Harford					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Fallston		Fallston General Hospital		Painter		Painting					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
13b. STATE Maryland		13c. COUNTY Harford		13e. STREET ADDRESS / ZIP CODE 2454 Conowingo Rd. 21014							
13f. FATHER'S NAME FIRST Otto		MIDDLE I.		LAST Beba		15. MOTHER'S MAIDEN NAME FIRST Susan		MIDDLE		LAST Sakerah	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Yes		1947-1948		188-22-1105		Stella P. Beba		same as above			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						3 days					
DUE TO, OR AS A CONSEQUENCE OF (b) Two primary Ca, in Rt lung.						3 months					
DUE TO, OR AS A CONSEQUENCE OF (c) Multiple metastases, adrenal incuff						"					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/12, 1985, to 3/15, 1985, that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Henry H. Kwan</i>		DEGREE and				ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/16/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY H. KWAN		22e. ADDRESS 437 GIRARD ST. HARFORD, MD 21078									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/18/1985		23c. NAME OF CEMETERY OR CREMATORIAL Highview Mem. Gar.		23d. LOCATION CITY OR TOWN Fallston, Harford, Md.		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz ADDRESS Jarrettsville, Md.											
25a. DATE REC'D. BY REGISTRAR MAR 21 1985						25b. REGISTRAR'S SIGNATURE <i>Gladden Kurtz</i>					



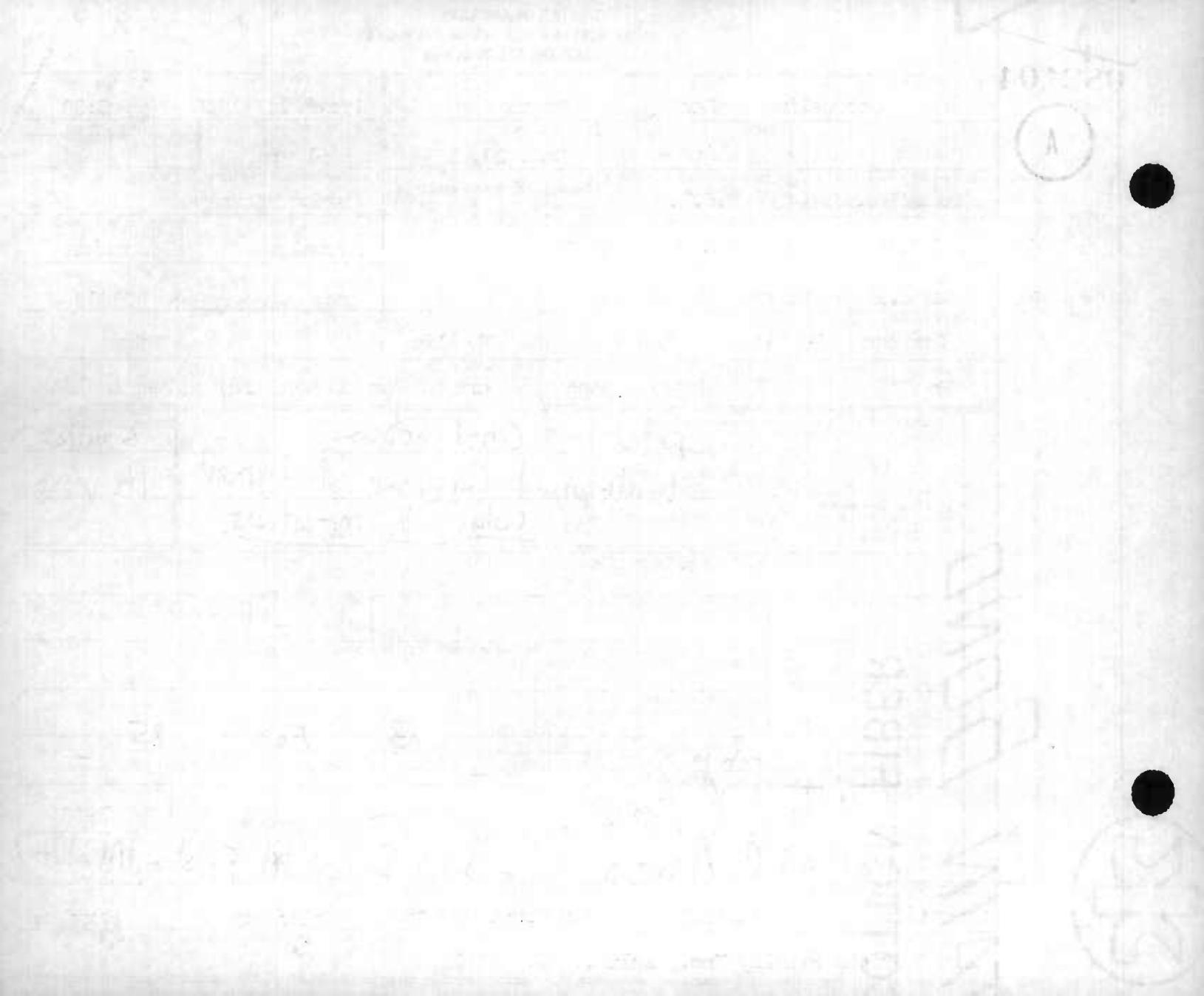
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8508588		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR A.M.			
Jacqueline Lee Berger						March 1, 1985			5:30			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
Female		White		Oct. 20, 1933			51 yrs. YRS.			IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Massachusetts		U.S.A.					Harford County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Bel Air		2058 Cabot Court		Recorder			Education					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland	Harford	Bel Air						2058 Cabot Court 21014				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS	
Herbert Stephen Lee		Phyllis			NO			215.30.9090			Robert G. Berger (Husband) (Same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for 18, 18b, and 18c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Widespread Carcinoma of Sigmoid</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>colon with metastases</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED P.M. 19			ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw, the deceased alive on <u>Feb 18 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									88	Feb	85	
22b. SIGNATURE <u>Willard P. Amoss</u>				DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 3/1/1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Willard P. Amoss</u>				22e. ADDRESS 2303 Belair Rd, Fallston, Md 21047								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/2/1985		23c. NAME OF CEMETERY OR CREMATORIAL Green Mount Crematory			23d. LOCATION CITY OR TOWN Baltimore		COUNTY	STATE Maryland		
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc., Balt., Md. 21222							25a. DATE RECEIVED BY REGISTRAR MAR 4 1985		25b. REGISTRAR'S SIGNATURE			
ADDRESS												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Please add 2 hours to the time listed after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Yes" then all shows any injury, or other traumatic event, the medical examiner will be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 08589			
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Willie James Blevins Jr.				Willie	James	Blevins Jr.	March 1	1985	2 p.m.	58			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male		Negro		August 19, 1941			43			MONTHS	IF UNDER 1 HRS		
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS			
Alabama		U.S.A.					Hartford			DAYS			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace		Harford Memorial Hosp								Rehabilitation Programs		STATE OF MD.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE					
Md.		Harford		Havre de Grace		YES <input checked="" type="checkbox"/>		667 Green st. 21078					
14. FATHER'S NAME		FIRST	MIDDLE	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST						
		Willie	James	Blerins, Sr.	ETHEL		Allen						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
YES		UNK		218-40-2140		ETHEL Blerins, 125 Hanover St. C-Aberdeen, Md. 21001							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
18. CAUSE OF DEATH (Enter only one cause per line for Part 1 and Part 2) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)													
DUE TO, OR AS A CONSEQUENCE OF Recent myocardial infarction													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-25, 1985 to 3-1, 1985, that (I) (we) last saw the deceased alive on 3-1, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE J.T. Lee		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		22e. MEDICAL DIRECTOR <input type="checkbox"/>		22f. STAFF PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED 3-1-85			
22h. PHYSICIAN'S NAME (TYPE OR PRINT) J.T. Lee		22i. ADDRESS Union Med. Clinic.											
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Mar. 9, 1985		23c. NAME OF CEMETERY OR CREMATORIAL ST. James United		23d. LOCATION CITY OR TOWN Havre de Grace, Harford, Maryland		23e. COUNTY		23f. STATE			
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A. Aberdeen, Md. 21001-3399		25a. ADDRESS A		25b. DATE REC'D. BY REGISTRAR MAR 8 1985		25c. REGISTRAR'S SIGNATURE John T. Lee							

201020



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8508590			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
ELSIE						BOOZE			3 1 85			905 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
Female		White		11 3 08			76 yrs								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			HARFORD MD			
Maryland			U.S.												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Fallston			PAI/Bon Sec Hosp			Secretary			Electrical						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e. STREET ADDRESS / ZIP CODE			
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 528 Applewood Dr. 21044					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Frederick Clagett			Lucretia Young												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			214-14-0164			Mr. Rodney Booze			Same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.															
(b) _____ DUE TO, OR AS A CONSEQUENCE OF Anemia															
(c) _____ BREAST CANCER															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the deceased) attended the deceased from 2/26 1985 to 19 _____, that (I) (we) last saw the deceased alive on 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22b. DATE SIGNED 3/1/85			
22c. SIGNATURE Andrew Nowakowski MD												DEGREE			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
ANDREW NOWAKOWSKI MD			125 N. MAIN ST. BEL AIR, MD												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 3/2/85			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN COUNTY STATE			23d. LOCATION CITY OR TOWN COUNTY STATE						
Removal															
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Anatomy Board			Balto., Md.												
MAR 05 1985															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

098125

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										85 08591				
										REG. NO.				
1 - FOR STATE REGISTRAR			2a DATE OF DEATH							MONTH	DAY	YEAR	2b HOUR	
I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST				3 23	85	35	3 PM	
John Gustave Bourgeois														
3. SEX			4. RACE			5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Male			White			MONTH 2 DAY 2 YEAR 32				53 yrs			MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
La.			U.S.A.							Harford County				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION				12b KIND OF BUSINESS OR (TYPE OF WORK FOR MOST OF WORKING LIFE) INDUSTRY				
Fallston			Fallston General Hospital			Research Scientist				Hospital				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a STREET ADDRESS / ZIP CODE				
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Joppa				750 Shore Dr. 21085				
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE											
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Leonce Charles Bourgeois			Marie Coralie Turcotte											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS					
Yes Korean			438-40-0286			Betty M. Bourgeois (wife)			same address					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Resuscitation</u>										immediate				
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u>										1 day				
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Artery Disease</u>										16 years				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>none</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>March 23, 1985</u> to <u>March 23, 1985</u> , that (I) (we) last saw the deceased alive on <u>March 23, 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Joseph Levine</u>										DEGREE MD				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph Levine</u>										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal										23b. DATE 3/23/85				
23c. NAME OF CEMETERY OR CREMATORIAL St. Louis #3										23d. LOCATION CITY OR TOWN New Orleans				
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 9705 B elair Rd. Balto. Md. 21236										25a. DATE REC'D. BY REGISTRAR APR 2 1985				
										25b. REGISTRAR'S SIGNATURE <u>Julie Sanderson Pendell</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, 201 W. Preston St., Baltimore, Md. 21201, to burial, cremation, or removal of body.

IMPORTANT: If item 21 is marked "Yes", then item 22a and 22b are to be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8508592									
												REG. NO.									
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST WILLIE			MIDDLE I.			LAST BROOKS.			2a. DATE OF DEATH MONTH 03-27-85		2b. HOUR 12:35 PM				
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH August			DAY 11			YEAR 1911			6. AGE (IN YEARS LAST BIRTHDAY) 73 years YRS		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS DAYS 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Harford			10 CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bombs & Frag. Test		12b. KIND OF BUSINESS OR INDUSTRY AberdeenProv. Gr		
13a. STATE Md.			13b. COUNTY Cecil			13c. CITY OR TOWN Perryville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1428 Frenchtown Rd. 21903									
14. FATHER'S NAME FIRST James			MIDDLE Brooks			LAST			15. MOTHER'S MAIDEN NAME FIRST Erma			MIDDLE Hail			ADDRESS Perryville, Md. 21903						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WW 11			17. INFORMANT Stella B. Brooks, 1428 Frenchtown Rd.			18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AS OOD.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost			b) COPD			c) COPD															
DUE TO, OR AS A CONSEQUENCE OF			DUE TO, OR AS A CONSEQUENCE OF																		
b) COPD			c) COPD																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 3/7/85									
22b. SIGNATURE Lee			22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lee			22e. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 30, 1985			23c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cemetery			23d. LOCATION CITY OR TOWN Colora		COUNTY		STATE Cecil Maryland								
24. FUNERAL DIRECTOR Lee A. Patterson & Son Lee A. Patterson & Son, Perryville, Md 21903									25a. DATE REC'D. BY REGISTRAR APR 2 1985		25b. REGISTRAR'S SIGNATURE Lee A. Patterson & Son										

Scored

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1M. RETAIN PAGES 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

08593

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08593

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
DOUGLAS CHARLES BURDETTE, SR.						<input checked="" type="checkbox"/>	3	1	1985	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	White	Oct. 7 1921	63 yrs.			3	1	1985	3:45 A.M.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Harford County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace		Harford Memorial Hosp.				Steel		Fabrication			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		21001			
Maryland		Harford	Aberdeen	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3731 Aldino Road					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	Metzler			
Harry			Burdette	Nellie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		WW-II		220-07-2020		Alan R. Burdette, 3729 Aldino Rd., Aberdeen,			Maryland 21001		
18. CAUSE OF DEATH (Enter only one or use per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Gunshot wound of head (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Self-inflicted.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
		home		3731 Aldino Rd., Aberdeen		Head Only		Harford	Md.		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
22b. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER											
22c. DATE SIGNED <u>3-1-85</u>											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <u>111 Penn St., Balto., Md. 21201</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>2 March 85</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>Cratin & Ferris</u>		23d. LOCATION CITY OR TOWN		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME		ADDRESS	25. DATE REC'D. BY REGISTRAR <u>MAK 5 1985</u>		26. REGISTRAR'S SIGNATURE <u>John L. Johnson - Jr.</u>						
Tarring Funeral Home, P.A., Aberdeen, Md. 21001-3399											

3

8508594

098034

1 - FOR
STATE
REGISTRATION

1 DECEASED NAME
1 TYPE OR PRINT

FIRST MIDDLE LAST
John Charles Caffrey

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR			
John Charles Caffrey						March 26, 1985		13	AM		53			
3. SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR				
Male		White		September 22, 1922			62 years			MONTHS DAYS				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 21 HRS				
New York		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Harford			MONTHS HOURS MIN.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY							
Avre de Grace		Harford Mem. Hospital					Owner/Driver			AirVetsBus Co				
13a STATE		13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS?		13e STREET ADDRESS / ZIP CODE					
Maryland		Cecil		Port Deposit			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		54 N. Main Street 21904					
14 FATHER'S NAME		FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME			FIRST MIDDLE LAST							
John				Mary					Marr					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes		WW 11		057-16-0226			Marie A. Caffrey, 54N. Main St., Port Deposit, MD							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>														
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u>														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION <u>3/15/85</u>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Small bowel obstruction & gangrene</u>			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>3-15-85</u> to <u>3-26-85</u> , that (I) (we) last saw the deceased alive on <u>3-26-85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE <u>John Charles Caffrey</u>		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>3/27/85</u>			
22d PHYSICIAN'S NAME (IF DIFFERENT) <u>AW ERICKSON</u>		22e ADDRESS <u>HAVERSE de GRACE MD 21078</u>												
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIUM			23d LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		March 29, 1985		Mt. Erin Cemetery			Havre de Grace, Harford		Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN. The 1 attended by the hospital or attending physician

HO HOSPITAL OR ATTEN-

DHMH - 16 60M 7/B4
(VRA 15, 4)

DHMH - 16 60M 7/B4
(VRA 15, 4)

**BURIAL, CREMATION, REMOVAL
(SPECIFY)**

23b. DA
Mao

23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM
March 29, 1985	Mt. Erin Cemetery

23d LOCATION CITY OR TOWN COUNTY STATE
Hayre de Grace Harford Md

2025 RELEASE UNDER E.O. 14176

LEADER DIRECTOR
Lee A. Patterson & Son ADDRESS
Lee A. Patterson & Son, Perryville, Md. 21903

25a DATE REC'D. BY REGISTRAR

APR 2 1985

b. REGISTRAR'S SIGNATURE

160660



092126
092126STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8595

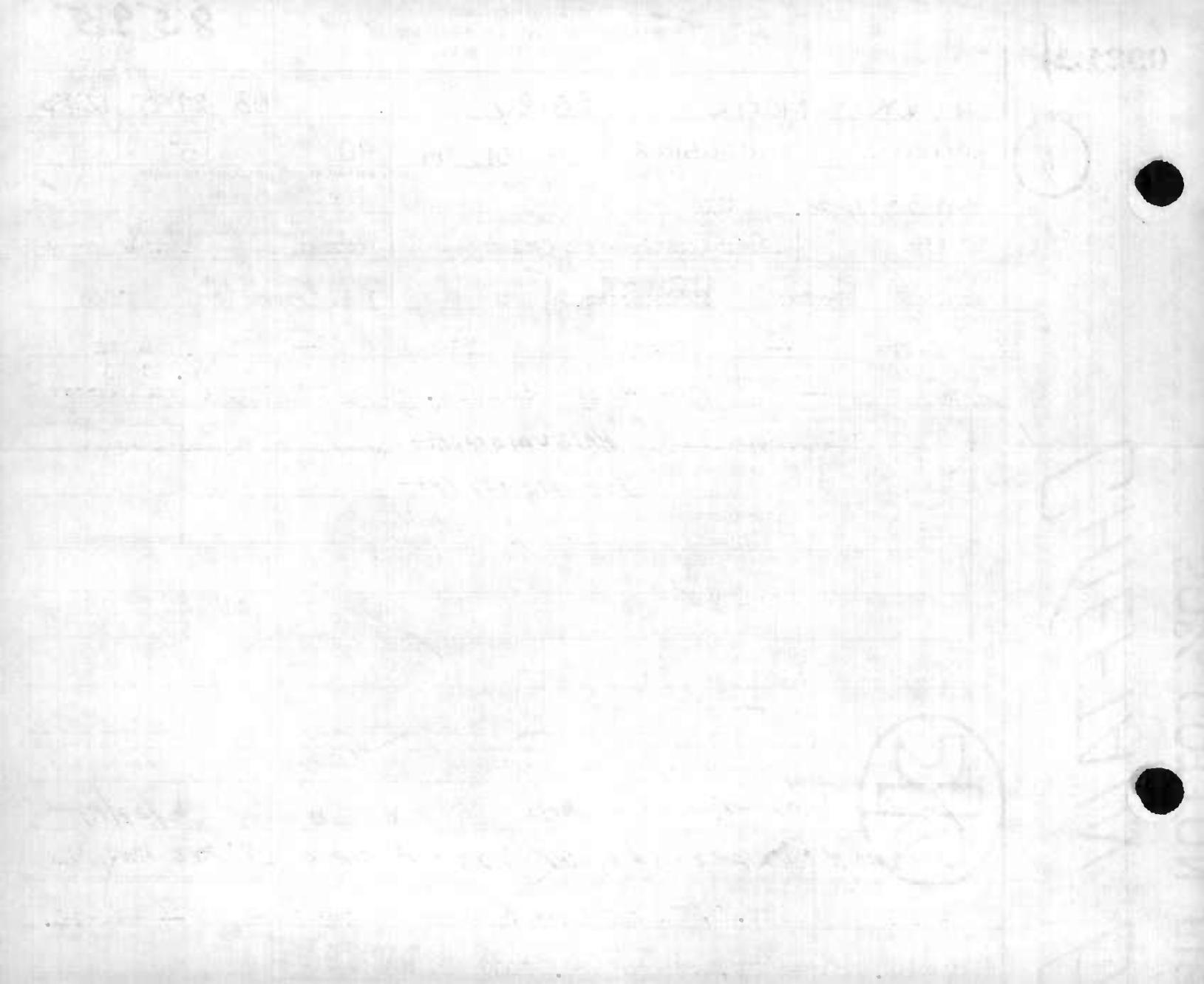
1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Helen			Marie	Carey		03	27	55	12:30 PM		
3. SEX			RACE	S. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	IF UNDER 24 HRS
female			caucasian	09	01	94	90	YRS	MONTHS	MONTHS	YEARS
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED	NEVER MARRIED	X	9. BALTIMORE CITY OR COUNTY OF DEATH			
Philadelphia, Pa.			USA	WIDOWED	DIVORCED		Harford County			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bel Air			Belair Convalescent Center			Foreman			Metal Decorating		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	YES	NO	13e. STREET ADDRESS / ZIP CODE			
Maryland			Harford	Edgewood	YES		1217 Hanson Road			21040	
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST
Thomas			—	—	Carey	Hilda			—	—	Turner
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS		
mp			214-24-6820			Richard C. Plitt, 1217 Hanson Road, Edgewood			Md. 21040		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Dementia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Andrew Nowakowski MD</i>		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/27/85</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Andrew Nowakowski, MD</i>		22e. ADDRESS <i>125 N. MAIN ST. BLD 19A, MD</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 29, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery		23d. LOCATION CITY OR TOWN Baltimore		COUNTY		STATE Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009		25a. DATE REC'D. BY REGISTRAR MAR 29 1985				25b. REGISTRAR'S SIGNATURE <i>John P. Burt</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and (immediately filled in by the funeral director, Page 3 should be detached for use as the Burial/Transit Permit. Then please remove carbon copy. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



086072

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08596			
1- STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) Janie Tildon Christy						2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> 3 19 1985			2b. HOUR MONTH DAY YEAR			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Mar. 1, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 3 19 1985		2d. HOUR MONTH DAY YEAR 3:55PM	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.									
10. CITY OR TOWN OF DEATH Aberdeen			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 415 Baltimore Street						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic			12b. KIND OF BUSINESS OR INDUSTRY Private			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 415 Baltimore Street/21001							
14. FATHER'S NAME FIRST Frank			MIDDLE Tildon		15. MOTHER'S MAIDEN NAME FIRST Annie		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS 21001			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY 8902 IMMEDIATE CAUSE (a) Smoke and soot inhalation and thermal burns DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:29PM 3/19 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) house fire									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK XX			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET 415 Baltimore St, CITY OR TOWN Aberdeen, Harford County, MD COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Margarita A. Korell, M.D.												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial			23b. DATE Mar. 21, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Cratin and Ferris			23d. LOCATION CITY OR TOWN West Chester/Chester/Penna. COUNTY STATE						
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399			25a. DATE REC'D. BY REGISTRAR 3/26/1985			25b. REGISTRAR'S SIGNATURE									
DHMH - 17 (VR A15 ME (5))															

513600

0821090

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be marked and checked.

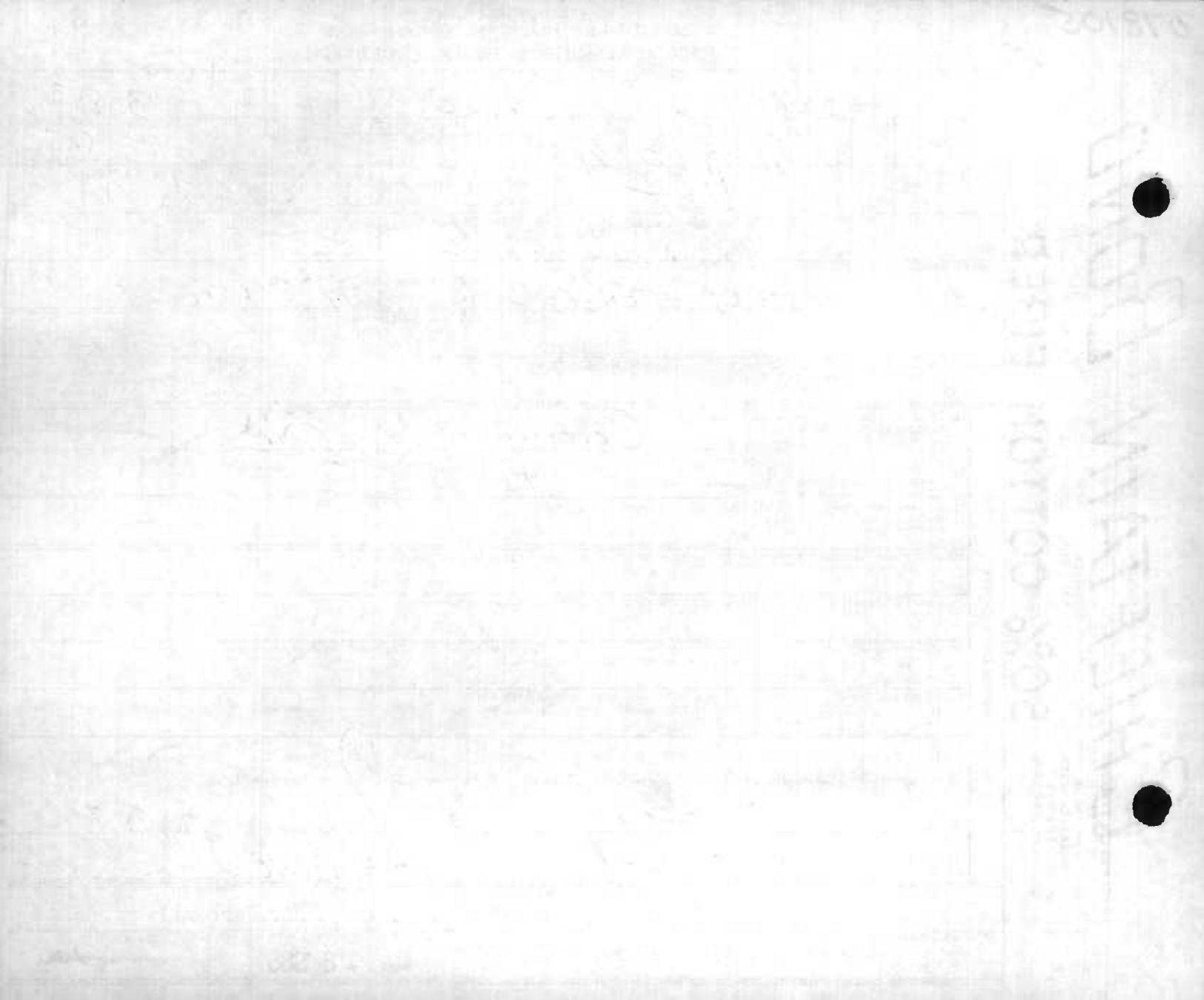
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												08597												
												REG. NO.												
1 - FOR STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST 10a Ola			MIDDLE C			LAST Clark			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
															3 8 85					6:00 PM				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			76		IF UNDER 1 YEAR		IF UNDER 24 HRS								
F			W			MONTH 7 DAY 17 YEAR 08			MONTHS			YRS.		MONTHS		DAYS		HOURS		MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			Harford		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Nova Scotia Canada			U.S.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			10a. HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			10b. CITY OR TOWN			11. 2605 Fallston Rd, Fallston, Harford			12a. STREET ADDRESS			12b. 21047			
Maryland			Harford			13a. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			13e. 2605 Fallston Road			13f. LAST NAME						
14. FATHER'S NAME FIRST Charles			MIDDLE —			LAST Price			15. MOTHER'S MAIDEN NAME FIRST Matilda			15f. LAST NAME			15e. STREET ADDRESS			15f. Delavallague						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			17d. ADDRESS			17e. Fallston, Md. 21047			17f. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.									
no			212-28-3536-B			Ronald A. Clark, 2605 Fallston Road																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												Myocardial infarction												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease												
DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.D.																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a)																								
19a. DATE OF OPERATION NA			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 3 8 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) March 1, 1985			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE									
22a. I certify that (I) (this hospital) attended the deceased from March 27, 1980, to March 1, 1985, that (I) (we) last saw the deceased alive on March 1, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																								
22b. SIGNATURE Benedicto J. Garsin			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/8/85															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BENEDICTO J. GARSIN			22e. ADDRESS 2412 Baldwin Mtn Rd Fallston																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Mar. 12, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens, Bel Air, Harford, Md.			23d. LOCATION CITY OR TOWN			COUNTY			STATE									
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009			ADDRESS			25a. DATE REC'D. BY REGISTRAR MAR 11 1985			25b. REGISTRAR'S SIGNATURE Natalie Johnson															

078105

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, LEAVE PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												08598									
											REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>HELEN</i>	MIDDLE <i>L.</i>	LAST <i>Cline</i>	2a. DATE KNOWN OF EST. DEATH MATED					MONTH <i>3/13</i>	DAY <i>85</i>	YEAR <i>1985</i>	1b. HOUR <i>07</i>							
3. SEX		4. RACE	5. DATE OF BIRTH MONTH <i>11</i>	DAY <i>13</i>	YEAR <i>83</i>	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS <i>61</i>	7. IF UNDER 1 YR. MONTHS <i>0</i>	8. IF UNDER 24 HRS. MONTHS <i>0</i>	9. HRS. <i>0</i>	10. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	11. DATE MONTH <i>3/13</i>	DAY <i>85</i>	YEAR <i>1985</i>	12. HOUR <i>10</i>				
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>West Virginia</i>			13. CITIZEN OF WHAT COUNTRY? <i>USA</i>			14. MARRIED <input checked="" type="checkbox"/>					15. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford</i>										
16. CITY OR TOWN OF DEATH <i>Havre de Grace</i>			17. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, ADDRESS OR LOCATION) <i>Hospital</i>			18. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>					19. KIND OF BUSINESS OR INDUSTRY										
20. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			21. STATE <i>MD</i>	22. COUNTY <i>Harford</i>	23. CITY OR TOWN <i>Havre de Grace</i>	24. INSIDE CITY LIMITS? YES <input type="checkbox"/>	25. STREET ADDRESS <i>214 S. Parke St.</i>	26. ADDRESS <i>21001</i>													
27. FATHER'S NAME FIRST <i>Bert</i>			MIDDLE <i>L.</i>	LAST <i>Stewart</i>	28. MOTHER'S MAIDEN NAME FIRST <i>Nellie</i>					29. ADDRESS <i>Stewart</i>											
30. WAS DECEASED EVER IN U.S. ARMED FORCES? (TEL. NO. OR UNKNOWN) <input type="checkbox"/>			31. SOCIAL SECURITY NO. <i>N/A</i>			32. INFORMANT <i>Walter Cline, 214 S. Parke St., Aberdeen, MD</i>					33. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
34. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): DUE TO, OR AS A CONSEQUENCE OF <i>Coronary heart disease</i>																					
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b): DUE TO, OR AS A CONSEQUENCE OF <i>ASCO</i>																					
35. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
36. DATE OF OPERATION			37. CONDITION FOR WHICH OPERATION WAS PERFORMED?									38. AUTOPSY?									
39. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			40. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			41. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 39 PART 1 OR PART 2)															
42. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			43. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			44. LOCATION STREET			45. CITY OR TOWN			46. COUNTY		47. STATE							
48. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												49. TITLE (SPECIFY) <i>M.D.</i>					50. MEDICAL EXAMINER			51. DATE SIGNED <i>3/14/85</i>	
52. ACTUAL SIGNATURE <i>Luis E. Fentel</i>			53. EXAMINER'S NAME (TYPE OR PRINT) <i>Luis E. Fentel</i>									54. ADDRESS <i>1111 N. Charles St., Baltimore, MD 21201</i>									
55. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			56. DATE Mar. 18, 1985			57. NAME OF CEMETERY OR CREMATORIAL Gdns.			58. LOCATION CITY OR TOWN <i>Bel Air, Harford, Maryland</i>			59. COUNTY <i>Harford</i>									
60. FUNERAL DIRECTOR <i>Tarling Funeral Home, PA</i>			61. ADDRESS <i>Aberdeen, MD, 21001-3399</i>			62. DATE REC'D. BY REGISTRAR <i>MAR 18 1985</i>			63. REGISTRAR'S SIGNATURE <i>Laurelton Rendall</i>												
64. D.M.H.M. - 17 (VR A15 ME (5))																					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, please return certificate to the funeral director. Page 3 should be detached to use as the burial permit. Then please remove certificate. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

093163

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8508599

1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR				2b HOUR 50				
I. DECEASED NAME FIRST MIDDLE LAST			March 29, 1985				12 AM				
1. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 75		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		White		April 3, 1909		YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford		MD.			
Iowa		USA									
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO. IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic/Welder		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed			
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Churchville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 11 Calvary Rd./21028			
14. FATHER'S NAME FIRST Alonzo		MIDDLE Martin		LAST Cockerham		15. MOTHER'S MAIDEN NAME FIRST Nancy		MIDDLE Belle		LAST Simmons	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT		ADDRESS		MD, 21028		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 4 weeks	
						Evelyn Cockerham, 11 Calvary Rd, Churchville,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1: DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Accident (Brain)</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonitis (Hypostatic)</u>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
				N/A							
21b. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21c. TIME OF INJURY HOUR: MIN. MONTH DAY YEAR		21d. HOW INJURY OCCURRED (Enter nature of injury in Item 21c, Part 1 or Part 2)							
		P.M. 19									
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		21f. PLACE OF INJURY (At home, street, factory, office, farm, etc.)		21g. LOCATION (Street)		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-27 1985</u> to <u>3-29 1985</u> that (I) (we) last saw the deceased alive on <u>3-29 1985</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Manuel M. Lopez</u> DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LAZATIN, MANUEL</u>		22e. ADDRESS PO Box 579		8 Law St.		Fountain Green, Harford, MD		22c. DATE SIGNED <u>3/29/85</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 1, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Mount Zion Cemetery		23d. LOCATION CITY OR TOWN		COUNTY STATE			
24. FUNERAL DIRECTOR NAME <u>Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399</u> ADDRESS <u>203 1005 11 Kil. Rd.</u> 25a. DATE REC'D. BY REGISTRAR <u>203 1005 11 Kil. Rd.</u> 25b. REGISTRAR'S SIGNATURE <u>John D. Doherty</u>											

POSITIONS OF
THE
ARMED
FORCES



082110

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												0 8 6 0 0							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	Ruby	MIDDLE	LAST	Colegrove	2a. DATE KNOWN OF DEATH ESTI- MATED			MONTH	DAY	YEAR	2b. HOUR					
3. SEX			F	W	4. RACE	5. DATE OF BIRTH MONTH	2	DAY	15	YEAR	6. AGE (IN YEARS (LAST BIRTHDAY)	76	YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.				
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			USA			8. MARRIED			NEVER MARRIED	WIDOWED	DIVORCED	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Fallston General			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Housewife			9. BALTIMORE CITY OR COUNTY OF DEATH	HARFORD			MD.
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			16901				
Pa			Tioga			WELSBORO			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			203 Ardmore's Tower			Joppatowne, Md. 21088				
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST				
Charles			—			Horton			Della			—			Webster				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
no			—			179-30-1929			Mrs. Patricia Welsh, 409 Garnett Road			Coronary Heart Disease							
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			DUE TO, OR AS A CONSEQUENCE OF			(b)			ASCVD										
(c)			DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE			TITLE (SPECIFY)			Luis E. Renjel, M.D., Deputy			MEDICAL EXAMINER			DATE SIGNED			3-9-85				
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			464 Alluvium St, Harford Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE				
Burial			3-13-85			Tioga Evergreen Cem.			Tioga			Tioga			Pa.				
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Howard K. McComas III, Abingdon, Md. 21009									MAR 11 1985			John W. Anderson - Handelle							

999999
BP
DHMH - 17
(VR A15 ME (5))
20M 4/82

011520



077129

08601

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Margaret M. Corbett						March 7, 1985				1:15A _M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR			
Fe		White		Month Day Year July 20, 1912		72				MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
New York		USA				Harford Co.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Fallston		Fallston General Hosp.				Government				U.S.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				99999	
Penns.		13b. COUNTY York	13c. CITY OR TOWN Fawn Grove			W. Main St.							
14. FATHER'S NAME		FIRST Mark	MIDDLE	LAST Flood	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.				17. INFORMANT		
					Bridget Casey		066-09-7370				ADDRESS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		17. INFORMANT				17321			
No						George E. Corbett, Sr. Fawn Grove, Pa.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Cardio pulmonary Arrest						SAME							
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart failure, chronic						Years							
DUE TO, OR AS A CONSEQUENCE OF (c) Previous Heart ATTACK													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 7 84 to 19 84, that (I) (we) last saw the deceased alive on 5-15-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.													
22b. SIGNATURE Nicholas J. Spagnola D.O.						DEGREE							
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Nicholas J. Spagnola D.O.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. ADDRESS Stewartstown PA						22e. DATE SIGNED 3-7-85							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/9/1985		23c. NAME OF CEMETERY OR CREMATORIAL Yorktowne Crem. Ser.		23d. LOCATION CITY OR TOWN York		COUNTY		STATE Penns.			
24. FUNERAL DIRECTOR NAME Kenneth W. Chuburn		ADDRESS Stewartstown, Penna.		17363		17363		MAR 12 1985		REG. NO. BY REGISTRAR REGISTRAR'S SIGNATURE Sue Harbin Pendleton			
(VR A 15 (4))													

100075

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 5 0 8 6 0 2			
1. FOR STATE REGISTRAR											REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
AUGUSTA			CORSALINI			03-29-85						11:15 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.		
female		cau.		8 28 92			92			YRS.					
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
Italy		U. S. A.					Harford						MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Bel Air		Belair Convalescent Ctr.			Home maker			Home							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Fallston			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			14. STREET ADDRESS 2110 Arden Drive 21047					
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
Natale				Tarsi			Adelaide						Manchenelli		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS							
no		216-54-2550			Mrs. M. Adelaide DeGele, Fallston, Md. 21047										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												19. MEDICAL INTERVAL BETWEEN DEATH AND CERTIFICATION			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.												/5/89			
(b) _____ (c) _____															
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. DATE SIGNED 3/29/85			
22b. SIGNATURE Linda Freiheit												DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			23d. LOCATION CITY OR TOWN Rossville			COUNTY Baltimore			STATE Md.				
Burial		4-1-1985			Gardens of Faith 21087										
23b. BURIAL, CREMATION, REMOVAL SPECIAL		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS			23d. LOCATION CITY OR TOWN Rossville			COUNTY Baltimore			STATE Md.				
24. FUNERAL DIRECTOR NAME		E. F. Lassahn, 11750 Belair Rd.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
		ADDRESS Kingsville, Md.			APR 03 1985			Linda Freiheit							

1960-1961

1

0821013

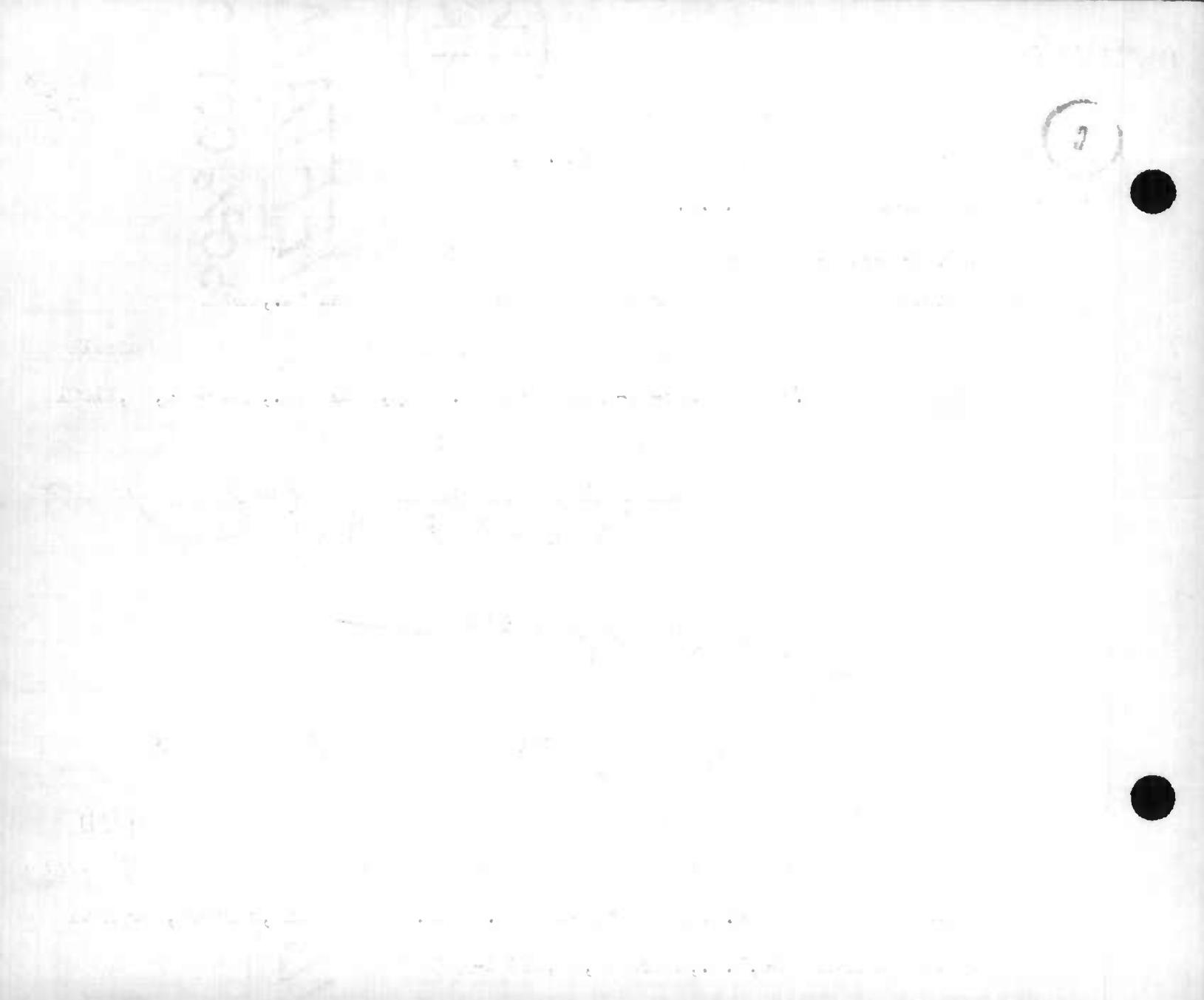
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Box 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 5 0 8 6 0 3				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Myrtle Frances Capp						3 2 85						50 2PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		Jan. 2, 1919			66			MONTHS	YEARS	MONTHS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Tennessee		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Harford							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Hause of Grace		Harford Memorial Hosp.		Homemaker										
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4 Law St., 21001				
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S M AIDEN NAME Russell						MIDDLE		LAST		
Hanna				Russell										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO		N/A		422-09-4311			Frank R. Capp, 4 Law St., Aberdeen, MD, 21001			1 hour				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary Arrest</i>														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Suspected Myocardial Infarction</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Atherosclerotic Heart Disease</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>applies</i>		20a. AUTOPSY? <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1983, 19, to 3/2, 1985, that (I) (we) last saw the deceased alive on 3/2, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <i>Mamie M. M. MD</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>3/2/85</i>										
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>LAZATIN, MAMIE</i>		22e. ADDRESS 8 Law St., Aberdeen, MD, 21001												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Mar. 6, 1985		23c. NAME OF CEMETERY OR CREMATORI Bel Air Mem. Gdns.			23d. LOCATION CITY OR TOWN Bel Air, Harford, Maryland			COUNTY	STATE			
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399		25a. DATE REC'D. BY REGISTRAR MMR 5 1985			25b. REGISTRAR'S SIGNATURE <i>J. L. Deacon</i>									
BP _____														
DHMH - 16 50M 4/83 (VRA 15, 4)														



088112

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

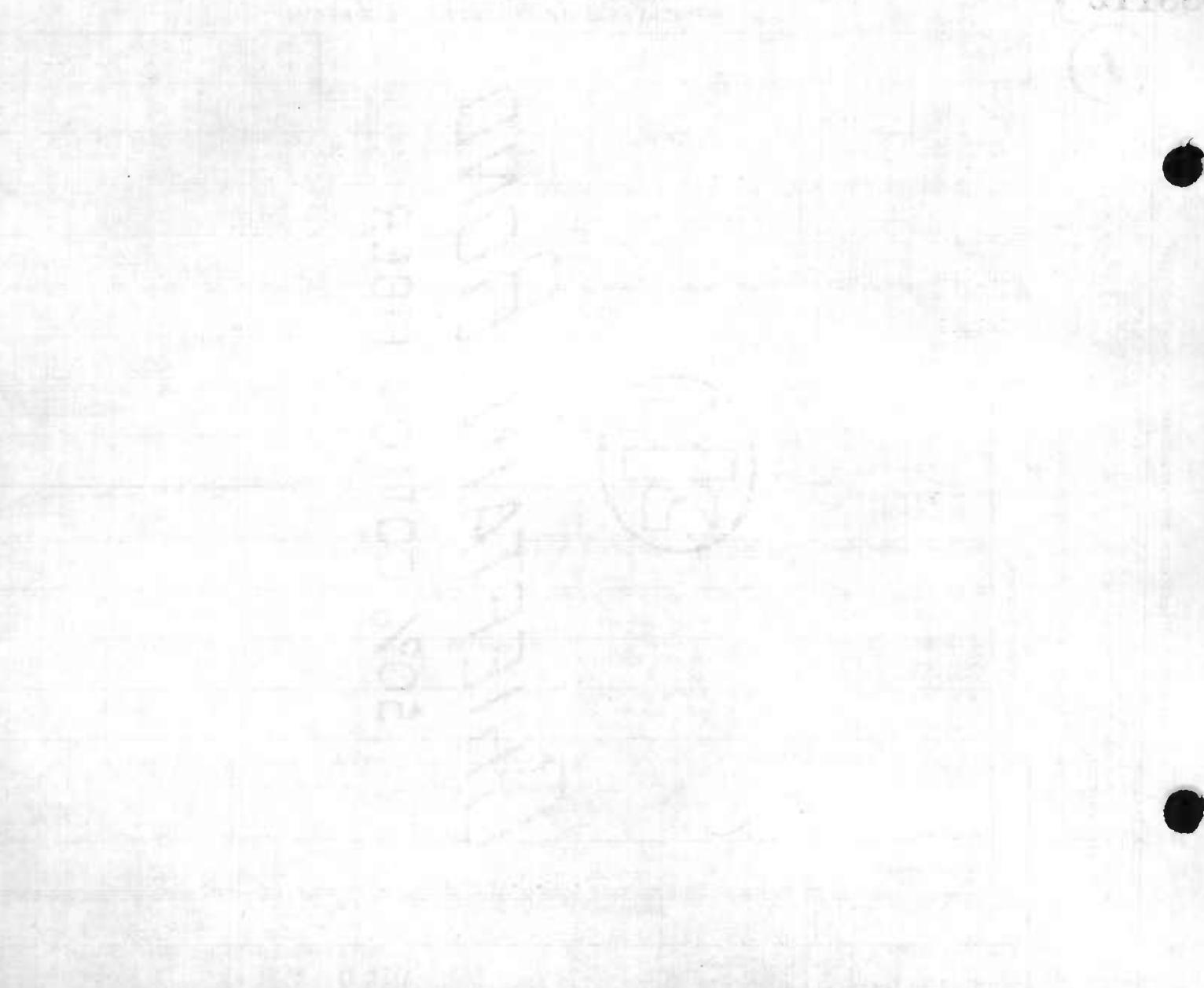
03604

REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF FUNERAL PRACTICE, 201 W. PINESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**1 - FOR
STATE
REGISTRATION**

1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED		MONTH DAY YEAR		2b. HOUR		
Michael			Shane			Cutlip			<input checked="" type="checkbox"/>		3 23 1985				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR 5:58
Male	White	1 11 1985	02 2 yrs.	2	12					3 23 1985		3	23	1985	5:58
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.						Harford County							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Fallston		Fallston General Hospital			Dependant										
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			Abingdon, MD			
Maryland		Harford		Abingdon			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3102 Emmerton Road			21009			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Michael Leo Cutlip			Rhonda L. Lanham												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No						Michael L. Cutlip			Same as 13e						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:															
7980 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause</u> lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>J. D. Duda</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER															
DATE SIGNED 3/24/85															
EXAMINER'S NAME (TYPE OR PRINT)		Gregory R. Kauffman, M.D.			ADDRESS			111 Penn St.			Balto. MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE				
Burial		3/26/1985		Bel Air Memorial Gdns.			Bel Air		Harford		Maryland				
24. FUNERAL DIRECTOR NAME		Duda-Ruck, Inc.			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
922 Wise Avenue		Dundalk, MD. 21222						MAR 26 1985			<u>J. D. Duda - Randall</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 more be retained by the hospital or attending physician.

098033

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 850

8605

1. DECEASED NAME (TYPE OR PRINT)			MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Adeline			Ruth	Devonshire	March 27, 1985			2 ¹⁴ P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR		
Female		white		February 1, 1913		72			MONTHS DAYS		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH			12. UNDER 24 HRS		
Maryland		USA				Harford			MONTHS DAYS		
13. CITY OR TOWN OF DEATH		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE, GIVE STREET ADDRESS)		15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			16. KIND OF BUSINESS OR INDUSTRY				
Havre de Grace		Harford Memorial Hosp		Housewife			-----				
17. STATE		18. COUNTY		19. CITY OR TOWN		20. INSIDE CITY LIMITS?			21. STREET ADDRESS / ZIP CODE		
Md.		Cecil		Colona		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			1767 Colona Rd. 21917		
22. FATHER'S NAME FIRST MIDDLE LAST		23. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		24. ADDRESS			25. APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH				
Auther		Jackson		Anna Mary Vannort			Colona, Md. 21917				
26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE IN WAR OR DATES		27. SOCIAL SECURITY NO.		28. INFORMANT			29. Joseph T. Devonshire, Jr., 1767 Colona Rd.				
No		215-32-3070									
30. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): QTA DUE TO, OR AS A CONSEQUENCE OF (b): HAS COP DUE TO, OR AS A CONSEQUENCE OF (c): D.M.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
31. DATE OF OPERATION		32. CONDITION FOR WHICH OPERATION WAS PERFORMED				33. AUTOPSY?		34. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
35. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (OR EITHER NOTIFY MEDICAL EXAMINER)		36. TIME OF INJURY HOUR: A.M. MONTH DAY YEAR P.M. 19		37. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 1 OR PART 2)		38. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
39. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		40. PLACE OF INJURY (EX. HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		41. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
42. I certify that (i) (this hospital) attended the deceased from <u>3-25</u> 19 <u>85</u> to <u>3-27</u> 19 <u>85</u> that (ii) (we) last saw the deceased alive on <u>3-27</u> 19 <u>85</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (ii) (we) (did) (did not) view the body after death.											
43. SIGNATURE		44. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		45. DATE SIGNED <u>3/27/85</u>							
46. PHYSICIAN'S NAME (TYPE OR PRINT)		47. ADDRESS <u>M. P. Munson Med. Clinic</u>									
48. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		49. DATE		50. NAME OF CEMETERY OR CREMATORIAL		51. LOCATION CITY OR TOWN					
Burial		March 30, 1985		West Nottingham Cemetery		Colona Cecil Maryland					
52. FURNERAL DIRECTOR <u>Lee A. Patterson & Son</u>		53. DATE REC'D. BY REGISTRAR		54. REGISTRAR'S SIGNATURE							
Lee A. Patterson & Son, Perryville, Md. 21903		APR 2 1985		<u>Richard Pendle</u>							

BP



670
44229
111

081019

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8606				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN MONTH	DAY	YEAR	2b. HOUR	
Timothy D. Eisner												EST. DEATH MATED	XX	3-8	1985	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS	8. IF UNDER 24 HRS. DAYS	9. DATE PRONOUNCED DEAD MONTH DAY YEAR	10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Male	White	8 21 1963	21			3-8 1985	Joppa	626 Shore Drive, Joppa, Md.			Mason			Presison Concrete		
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Joppa			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 626 Shore Dr. 21085				
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST				
James			F.			Eisner Sr.			Sharon			Cliffe				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. ADDRESS			17. INFORMANT			626 Shore Dr.				
no			214-70-8252						Mrs. Sharon Mayberry, Joppa, Md. 21085							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>												DUE TO, OR AS A CONSEQUENCE OF				
(b)												DUE TO, OR AS A CONSEQUENCE OF				
(c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY EST. HOUR A.M. MONTH DAY YEAR ? P.M. 3-8 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject hung himself			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home			21f. LOCATION STREET 626 Shore Drive, Joppa, Harford Co., Md.			CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <i>[Signature]</i>												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.												DATE SIGNED 3-9-85				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 3-12-1985			23c. NAME OF CEMETERY OR CREMATORIAL Holly Hill Mem. Gardens Middle River			23d. LOCATION CITY OR TOWN Baltimore Md.							
Burial																
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR MAR 18 1985			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							
E. T. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087																

802 878 AM -

091033

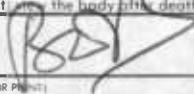
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copy. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 036017						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR	
CHESTER ALVIN EVERETT			EVETT			March 21, 1985			3 A.M.							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
MALE		White		December 16, 1901			83			MONTHS		DAYS		HOURS		
YRS.																
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Chester Hill Maryland		U.S.A.					Harford County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Forest Hill (21050)		203 Woodlawn Drive			Barber			Barber Shop Owner								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										21050						
13a. STATE Maryland		13b. COUNTY Harford Co.		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 203 Woodlawn Drive								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST						
William		Wilson		EVERETT		Hannah		Robinson		WARD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Sex) 838-3265 ADDRESS												
NO		216-20-7435		Mr. William Wilson EVERETT Bel Air, Maryland 21014												
18. CAUSE OF DEATH (Enter only one cause per line for a, (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Cardiac arrest. sudden death																
DUE TO, OR AS A CONSEQUENCE OF (b)										COPD. ASCVD- CHF — 10 yrs.						
DUE TO, OR AS A CONSEQUENCE OF (c)										Stroke.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) _____ the body after death.																
22b. SIGNATURE 																
22c. DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED March 22, 1985																
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. D. Patel, M.D.																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE March 23, 1985		23c. NAME OF CEMETERY OR CREMATORIAL CENTRE METHODIST CEMETERY			23d. LOCATION CITY OR TOWN FOREST HILL, HARFORD CO, MARYLAND 21050									
Burial																
24. FUNERAL DIRECTOR Joseph William Foster 50 W. Broadway & Williams St., ADDRESS Synderoller Foster BEL AIR, MARYLAND 21014																
25a. DATE (CD) BY REGISTRAR OR REGISTRAR'S SIGNATURE MAR 26 1985 Julia [Signature]																

660260

28th Nov 1944

1944

28th Nov, 1944

28th Nov

082102

3 5 0 8 6 0 8

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR March 2 1985										2b HOUR 8 p.m.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR 8 p.m.		
Mary			Bowser			Ferrell			March 2 1985					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female			Black			March 17, 1911			73					
7a BIRTHPLACE COUNTRY			7b CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH Harford			MD.		
Maryland			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>								
10. CITY OR TOWN OF DEATH Harford			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Harford Memorial Hospital			12a USUAL OCCUPATION Homemaker			12b KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md.			13b. COUNTY Harford			13c. CITY OR TOWN Aberdeen			13e. STREET ADDRESS / ZIP CODE 308 Stevens Circle Apt. 1D 21001					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Robert			Caroline											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No N/A			215-36-1646			J. M. Elliott, 308-1-D, Stevens Circle, Aberdeen, Md., 21001								
18 CAUSE OF DEATH (Enter only one cause per line for a, (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio - pulm. arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												(b) <u>Irreversible CCF 5/8 M</u>		
(c) <u>Cardiac arrest Dis. Cardiac</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cholesterol</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from 2-7, 1985, to 3-2, 1985, that (1) (we) last saw the deceased alive on 3-2, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 3/5/85		
22b. SIGNATURE <u>John Carson</u>			22d. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John Carson</u>			22f. ADDRESS 611 S. Union Ave Hauredy Grace											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE March 6, 1985			23c. NAME OF CEMETERY OR CREMATORIUM Union United Cemetery			23d. LOCATION CITY OR TOWN Aberdeen Harford Maryland			STATE		
24. FUNERAL DIRECTOR NAME Tanning Funeral Home, P.A., Aberdeen, MD, 21001-3399			25a. DATE REC'D. BY REGISTRAR MAR 8 1985			25b. REGISTRAR'S SIGNATURE <u>John Carson - Harford</u>								
BP														
DHMH - 16 60M 7/84 (VRA 15, 4)														

078149 5/22/85 Item #13 L.J. STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0809

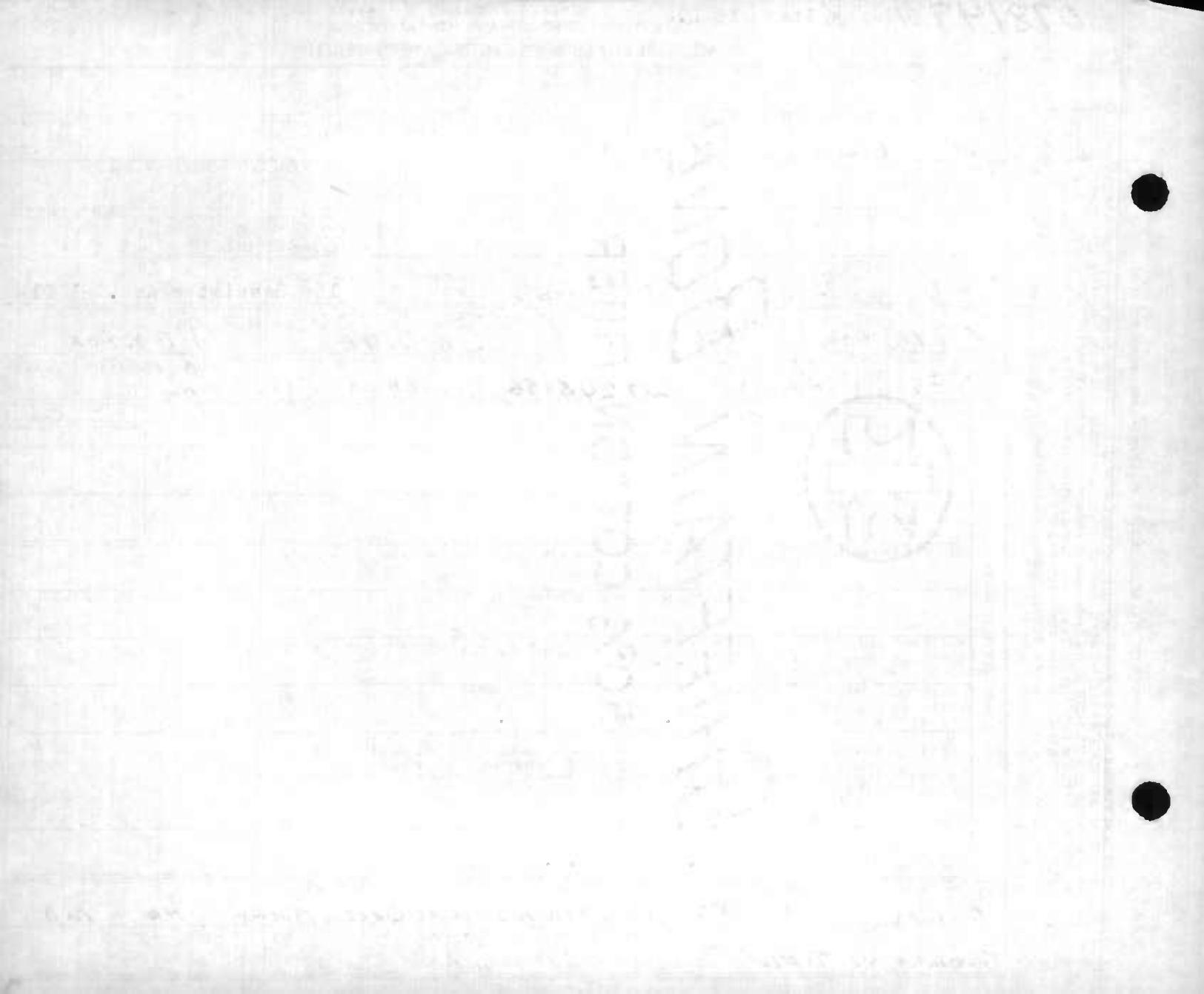
REG. NO.

1- STATE
REGISTRAR

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR		
RICHARD			IRVINE	FLICHTMAN		3-1-85	19		M			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN							
M	Black	3 30 31	53 yrs.									
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			11. CITIZEN OF WHAT COUNTRY?			12a. MARRIED WIDOWED		12b. NEVER MARRIED DIVORCED			13. DATE PRONOUNCED DEAD	
MD			USA			<input checked="" type="checkbox"/>		<input type="checkbox"/>			3-1-85 19 9:55P	
13. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Harve deGrace			Harford Memorial Hospital			LABORER			us Gov-			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
MD			Harford		Ahenderon	YES <input checked="" type="checkbox"/>		158 Bannister Ave. 21001				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	PAXTON		
Clinton				FLICHTMAN	CARRIE					OWEN MILK MD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
(IF YES, GIVE WAR OR RATES) ARMY			212 24 5356			RICHARD FLICHTMAN JR						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7 8122 IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last</u> } (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY 9PM 3-1-85 DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 2) driver of a motorcycle in collision with an auto head-on			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.			21f. LOCATION STREET Rt. 22			CITY OR TOWN Harford County, Maryland COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <i>Margarita Korell</i>			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER						DATE SIGNED 3-3-85			
EXAMINER'S NAME (TYPE OR PRINT)			111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 3-5-85			23c. NAME OF CEMETERY OR CREMATORIAL BELAIR MEMORIAL GARDEN BULMAN			23d. LOCATION CITY OR TOWN Baltimore MD COUNTY MD STATE			
24. FUNERAL DIRECTOR NAME GEORGE W TITTLE			ADDRESS 3836 30th Federal Rd JARRETHSVILLE MD			25a. DATE REC'D. BY REGISTRAR MAR 18 1985			25b. REGISTRAR'S SIGNATURE <i>Richard Pendleton</i>			
DHMH - 17 (VR A15 ME (5))												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by _____

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Page 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

08514081

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 5 0 8 6 1 0						
1- FOR STATE REGISTRAR												REG. NO.						
1. DECEASED NAME (FATHER'S NAME)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Everett			Nicholas			Franz						03-20-85					1:34 A.M.	
2. SEX		3. RACE		4. DATE OF BIRTH			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR		7b. IF UNDER 24 HRS				
M		White		Month Day Year			Month Day Year			67		MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		Harford County						
New Jersey		USA		April 13, 1917								MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Fallston		Fallston General Hospital										Program Analyst		US-govt. Ret.				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE		2200 Perry Avenue 21040						
Maryland		Harford		Edgewood			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			ADDRESS		Md. 21040						
14. FATHER'S NAME		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME			LAST								
George		—		Franz			Lenora			Buckingham								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
Yes		WWII		139-03-8960			Mrs. Virginia Franz, 2200 Perry Ave, Edgewood											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>cardiac arrest</i>																		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>coronary artery disease</i>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Bente Parvachis</i>																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>3/18/85</i> to <i>3/20/85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED						
22b. SIGNATURE <i>Man</i> DEGREE												ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (NAME OR PRINT)		22e. ADDRESS <i>1716 Harford Road, Dallas, TX 75201</i>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			23e. COUNTY		23f. STATE						
Burial		Mar. 23, 1985		Eglington Cemetery			Clarksboro			Gloucester		N.J.						
24. FUNERAL DIRECTOR NAME		25a. ADDRESS <i>Howard K. McComas III, Abingdon, Md. 21009</i>										25b. DATE REC'D. BY REGISTRAR		25c. REGISTRAR'S SIGNATURE <i>Sylvia Swanson-Fordham</i>				
BP _____												MAR 21 1985						
DHMH - 16 60M 7/84 (VRA 15, 4)																		

001620

2011-00000000

1. 2011-00000000 2011-00000000

2. 2011-00000000 2011-00000000

3. 2011-00000000 2011-00000000

4. 2011-00000000 2011-00000000

5. 2011-00000000 2011-00000000

222 115

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be delivered for use on the burial permit. Then release remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be consulted.

087142

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 08613

8508613

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME Joseph Littleton Gatchel			2a. DATE OF DEATH March 20, 1985	2b. MONTH March	2c. DAY 20	2d. YEAR 1985	2e. HOUR 10²² AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH December DAY 1 YEAR 1919	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS 65 YEARS 0	7. IF UNDER 1 YEAR MONTHS 0 DAYS 0			8. IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE STATE OR FOREIGN Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co.				
10. CITY OR TOWN OF DEATH Harve de'Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supply & Management			12b. KIND OF BUSINESS OR INDUSTRY Medical Center
13a. STATE Maryland		13b. COUNTY Cecil	13c. CITY OR TOWN Port Deposit	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 304 Jackson Park Road, 21904			
14. FATHER'S NAME: FIRST Woodward MIDDLE A. LAST Gatchel		15. MOTHER'S MAIDEN NAME FIRST Alice MIDDLE E. LAST Krauss			16. ADDRESS Port Deposit, Md. 21904			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>		16b. SOCIAL SECURITY NO. WW 11 215-18-9461		17. INFORMANT Gloria S. Gatchel, 304 Jackson Park RD.		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest.								
18b. DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
18c. DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD. & CVA								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. 19 P.M. 19 MONTH March DAY 20 YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 11/27/84 to 19 , that (I) (we) last saw the deceased alive on 11/27/84 at 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.								
22b. SIGNATURE Brian T. Yeo		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 3/20/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian T. Yeo, M.D.		22e. ADDRESS 801 S. Union Ave. Havre de Grace, Md. 21078						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 23, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Asbury Cemetery			23d. LOCATION CITY OR TOWN Port Deposit, Cecil Maryland	
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md. 21903				25a. DATE REC'D. BY REGISTRAR MAR 26 1985			25b. REGISTRAR'S SIGNATURE John W. Pendleton	

541580

First Qua

094039

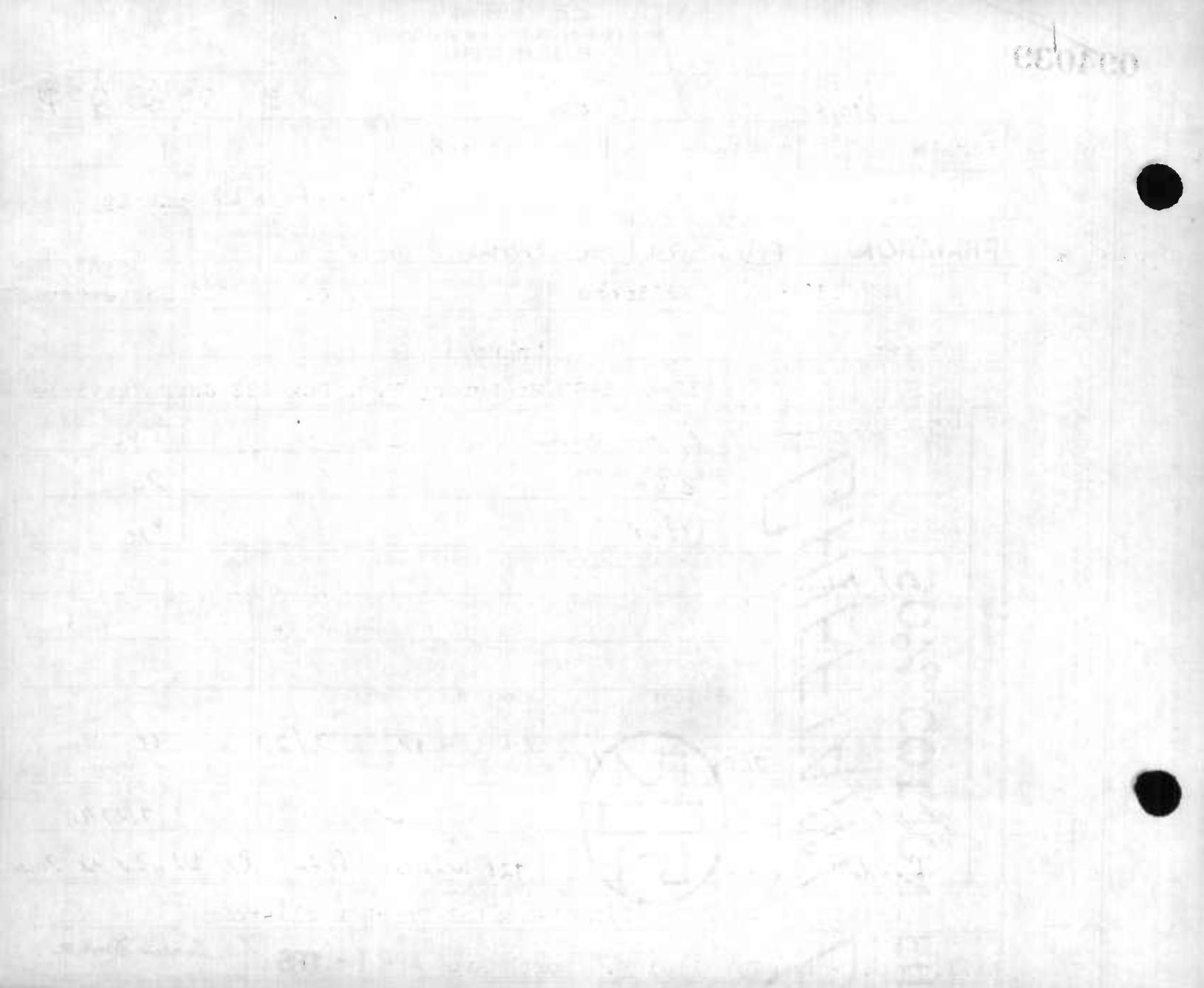
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8508614

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>VIOLET</i>	MIDDLE 6	LAST BISON	2a. DATE OF DEATH MONTH 9	DAY 13	YEAR 1904	2b. HOUR 3.24.85 253M	
3. SEX female		4. RACE White	5. DATE OF BIRTH MONTH 9			6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N/A		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD county MD.			
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Fallston		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P. O. Box 233 Jarrettsville 21080 Md		
14. FATHER'S NAME FIRST Unknown		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Unknown			MIDDLE	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-46-1852			17. INFORMANT Mr Puring P.O. Box 233 Jarrettsville			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 510m.2		
<p>18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cordis Arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>CHF</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASCVB</i> </p>										
<p>18. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Cor Pulmonale</i></p>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
<p>22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 19 80</i> to <i>3/27 1985</i>, that (I) (we) last saw the deceased alive on <i>3/26 1985</i>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</p>									22b. SIGNATURE <i>Randall Cronin</i> DEGREE	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Randall Cronin</i>		22e. ADDRESS 721 Wheeler School Rd. Whiteford, MD 21160			22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED 3/27/85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/1/85		23c. NAME OF CEMETERY OR CREMATORIAL King Memorial Park			23d. LOCATION CITY OR TOWN Randallstown			
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave		25a. ADDRESS ADDRESS			25b. DATE REC'D. BY REGISTRAR		25c. REGISTRAR'S SIGNATURE <i>Susan Davidson Pendell</i>			
BP		APR 1 - 1985								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. *Form 3* should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages *1* and *2* should be filled within 72 hours after death.TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages *1* and *2* should be filled within 72 hours after death. *Form 3* should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages *1* and *2* should be filled within 72 hours after death.IMPORTANT: If Item 21 is marked *Yes*, Item 18 shows any injury, or other traumatic event, the medical examiner



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy permit.葬儀所2号と2号

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8508615				
1 - FOR STATE REGISTRAR						REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST Helen	MIDDLE B.	LAST Gilbert	2a. DATE OF DEATH MONTH YEAR March 12 1985	DAY YEAR 3:25 PM			
3. SEX Female		4. RACE White	5. DATE OF BIRTH MONTH YEAR FEBRUARY 6, 1899			6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	IF UNDER 1 YEAR MONTHS DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford				
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Mem. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY MD.		
13a. STATE MD		13b. COUNTY HARFORD	13c. CITY OR TOWN HAVRE de GRACE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 415 SOUTH MARKET STREET 21078				
14. FATHER'S NAME FIRST JOHN		MIDDLE C.	LAST BOWEN	15. MOTHER'S MAIDEN NAME FIRST CLARA		MIDDLE MAY	LAST GILBERT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217 36 26760			17. INFORMANT MRS. ANNA GILBERT 121 DARLINGTON RO. HAVRE de GRACE, MO 21078					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterial coronary artery</i>										
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arterial sclerosis</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>A 20 TENTIA & PNEUMONIA</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3-8, 1985, to 3-12, 1985, that (I) (we) last saw the deceased alive on 3-12, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED 3/2/85	
22b. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22e. ADDRESS Dante Monaril Havre de Grace, Md 21078										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) S C BURIAL		23b. DATE 15MARCH85		23c. NAME OF CEMETERY OR CREMATORIUM SMITH CHAPEL CEMETERY		23d. LOCATION CITY OR TOWN CHURCHVILLE HARFORD CO., MD.				
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078									25a. DATE REC'D. BY REGISTRAR MAR 14 1985	25b. REGISTRAR'S SIGNATURE John E. Johnson
DHMH - 16 60M 7/84 (VRA 15, 4)										



08616

098126

TIMEONE 201 W 10TH ST MIAMI, FL 33130

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR OR MEDICAL EXAMINER IN ITEM 1A. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER WITH FORM FM 3. RETAIN PAGE 5 ON YOUR PERSON. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR RECORDS. PAGE 4 SHOULD BE FILED IN YOUR RECORDS. PAGE 5 SHOULD BE FILED IN YOUR RECORDS. **BA 1000** BALTIMORE, MARYLAND. 21201 PER TO BURIAL, CREMATION, OR REMOVAL.

BP 1092
DHMH - 17
(VR A15 ME (5))
20M 4/B2

3301-1000

W. DODD



661000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the Burial Transit Permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8508617																										
1 - STATE REGISTRAR											REG. NO.																											
I. DECEASED NAME			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR																						
Fuller			Reynolds			Gorham						3	26	85		5 40 AM																						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS																							
Male			White			MONTH DAY YEAR			75			MONTHS DAYS			HOURS MIN.																							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																	
New York			USA			June 11, 1909									Havre de Grace			Harford Memorial Hospital			Key Punch Oper.			US Gov't.														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c.) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			ADDRESS Havre de Grace, MD, 21078 Lee R. Gorham, c/o 300 Giles St., Apt. 6			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Maryland			Harford			Havre de Gra.						300 Giles St., Apt. 6/21078			Fuller			Agnes E. McCulloch			NO			N/A			226-09-9366			Lee R. Gorham								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c.) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a)																																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE																							
22a. I certify that (1) (this hospital) attended the deceased from _____ to _____, 19_____, that (1) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (1) (we) did not view the body after death.																																						
22b. SIGNATURE R. Lee						DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																		22c. DATE SIGNED 3/8/85											
22d. ADDRESS Union Med. Clinic, Havre de Grace																																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Removal			23b. DATE Mar. 28, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Hebron Cemetery			23d. LOCATION CITY OR TOWN Winchester,			COUNTY			STATE Virginia																							
24. FUNERAL DIRECTOR Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399									25a. DATE REC'D. BY REGISTRAR APR 1 1985			25b. REGISTRAR'S SIGNATURE Julie Davidson-Pendell																										

815000

A



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be attached to this certificate. Page 3 should be detached for use as the burial and Mental Health permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial and Mental Health permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

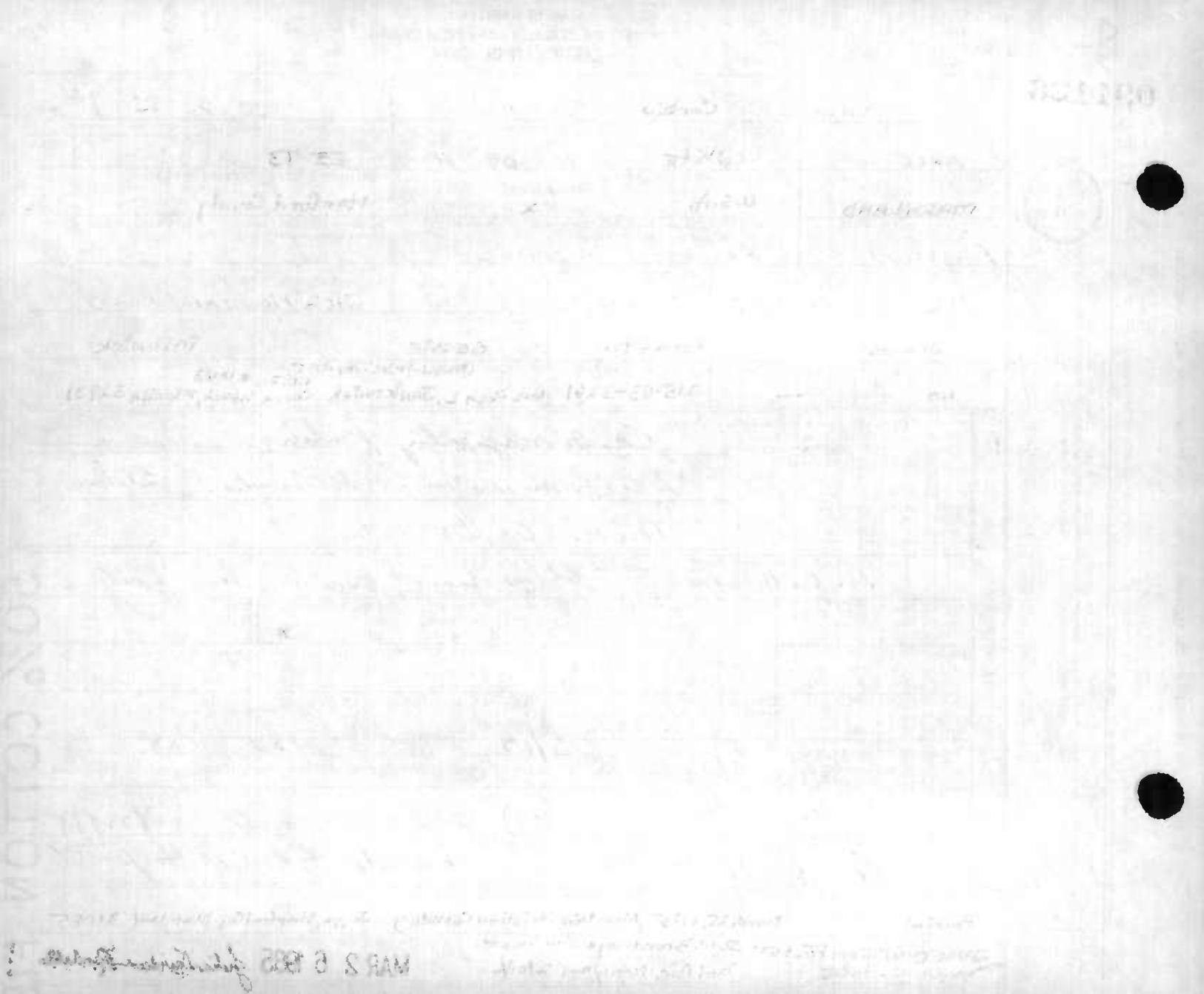
091126

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

85 08618

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			WILLARD	Corbin	GRAFTON	03	22	85	955			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
MALE		White		MONTH	DAY	YEAR	73	YRS	MONTHS	DAYS	HOURS	MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		U.S.A.				Harford County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
FALLSTON		FALLSTON HOSPITAL				21085						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		MD.		
MD		HARFORD		JOPPA				2102 MOUNTAIN ROAD				
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST		
JAMES				Grafton		BESSIE				MINNICK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. ADDRESS P.O. Box #1043 Mrs. ROSA L. JANKOWIAK Cocoa Beach, Florida 32931		17. INFORMANT (NAME) 305-784-0145 ADDRESS						
NO		215-03-3261										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <i>Cardiopulmonary failure</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Electromechanical dissociation</i> 24 hr.												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiac arrhythmias</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				<input type="checkbox"/> YES <input type="checkbox"/>		<input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on		3/12 1985		to 3/22 1985		that (1) (we) last viewed the body after death.						
22b. SIGNATURE <i>John L. Martin</i>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/22/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>A. B. MARTIN</i>		22e. ADDRESS Fallston General Hospital										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE March 25, 1985		23c. NAME OF CEMETERY OR CREMATORIUM Mountain Christian Cemetery		23d. LOCATION CITY OR TOWN JOPPA, HARFORD CO., MARYLAND 21085		23e. COUNTY STATE				
24. FUNERAL DIRECTOR Joseph William Foster Superior Caskets		ADDRESS 50 W. Broadway & Williams St. Bel Air, Maryland 21014		25a. DATE REC'D. BY REGISTRAR MAR 26 1985		25b. REGISTRAR'S SIGNATURE <i>John L. Martin</i>						



078032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove car bonpapers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 6 1 9

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
marie Elizabeth grimes						3	15	85		12 <u>AM</u>	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)			7b HOUR		
F		B		MONTH	DAY	YEAR	62			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
Md.		USA							Harford		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY		
Havre de Grace		Harford Memorial Hospital				Disabled					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE		
Md.		Harford		HavreDeGrace		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			387 Wilson St. 21078		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME			LAST			
		Charles	Alfred	Holland	Helen			Christy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				
No		214-36-9112		Leon Grimes same as above							
18 CAUSE OF DEATH (Enter only one cause per line) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)											
Reptics Vascular Stock today											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Final Failure</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis + Diabetes</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Hepatic Failure											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2/28, 19 85, to 3/15, 19 85, that (I) (we) lost saw the deceased alive on 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dante Monokic		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/15/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONOKIC		22e. ADDRESS Havre de Grace, Md 21078									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/19/85		23c. NAME OF CEMETERY OR CREMATORIAL Union United Meth.			23d. LOCATION CITY OR TOWN Aberdeen		COUNTY Harford	STATE Md.	
24 FUNERAL DIRECTOR Arnold Beard		25a. DATE REC'D. BY REGISTRAR MAR 18 1985				25b. REGISTRAR'S SIGNATURE John Anderson-Fordell					
NAME ADDRESS											

20 22 23 24 25

below

0705 0710 0715 0720 0725 0730 0735

0740 0745 0750 0755 0800 0805 0810

0815 0820 0825 0830 0835 0840 0845

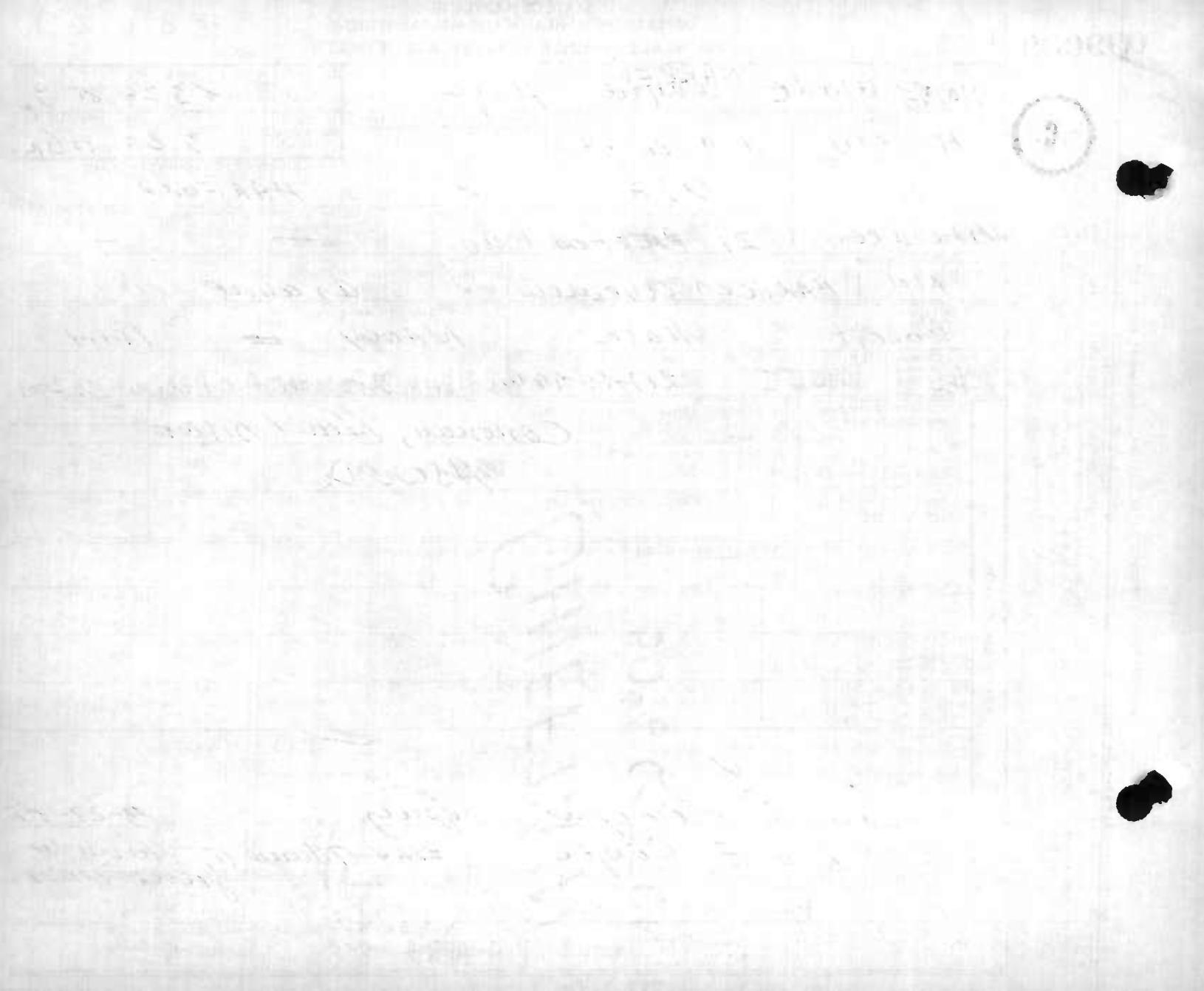
0850 0855 0900 0905 0910 0915 0920

0925 0930 0935 0940 0945 0950 0955

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3, RETAIN PAGE 5 FOR OUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08620									
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED									2b. HOUR									
1. DECEASED NAME (TYPE OR PRINT)			FIRST WAYNE Wade			MIDDLE WARREN Wallace			LAST Haga			MONTH DAY YEAR		3 PM							
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. HOUR 24. HOUR					
11. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS as above 21001				21 Pritchard Ave								
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			NANCY # 15044							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		16d. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
YES		WA 11		217-18-9920 R.G. Haga, 21 Pritchard Ave, Aberdeen, MD. 21001																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____														Coronary Heart Disease ASCD							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). 19a. DATE OF OPERATION														19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE		TITLE (SPECIFY) Luis E. Renjel M.D. Deputy MEDICAL EXAMINER												DATE SIGNED 3-27-85							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS Luis E. Renjel 464 Alluvio St. Harford																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE											
Burial		Mar. 26, 1985 Bel Air Mem. Gdns.				Bel Air		Harford		Maryland											
24. FUNERAL DIRECTOR NAME		ADDRESS Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3011 APR 1 1985												25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							
DHMH - 17 (VR A15 ME (5)) 15M 7/77																					



074057

81

A

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 3
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death
 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 8 0 2 2		
												REG. NO.		
1. FOR STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
Niels THURDE HANSEN						March 13 1985			11:22 AM					
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
MALE		WHITE		OCTOBER 2, 1909			75 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			10 IF UNDER 24 HRS MONTHS DAYS HOURS MIN.				
DENMARK		USA					Harford							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Havre de Grace		Harford Memorial Hospital		(RET) RESIDENT MANG.			APARTMENT BUILDING							
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN HARFORD			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 608 ST JOHNS TOWERS/CONGRESS AVE 21078				
14. FATHER'S NAME FIRST PETER		MIDDLE ADREAS		15. MOTHER'S MAIDEN NAME LAST HANSEN ASTA										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 113 20 7472		17. INFORMANT LILLIAN C. HANSEN			ADDRESS SAME AS #13e							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u>														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ho of TIA</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>3/11/85</u> to <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 3/13/85		
22b. SIGNATURE <u>Brian T. Yeo</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Brian T. Yeo, M.D.</u>			22e. ADDRESS <u>Union Ave, Havre de Grace MD</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 14MARCH85			23c. NAME OF CEMETERY OR CREMATORIAL FERRIS AND CO.			23d. LOCATION CITY OR TOWN WEST CHESTER, COUNTY PA.					
24. FUNERAL DIRECTOR NAME MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078						25a. DATE REC'D. BY REGISTRAR MAR 18 1985			25b. REGISTRAR'S SIGNATURE <u>Suzanne Dawson-Henderson</u>					

RECEIVED
LIBRARY

1948



074032

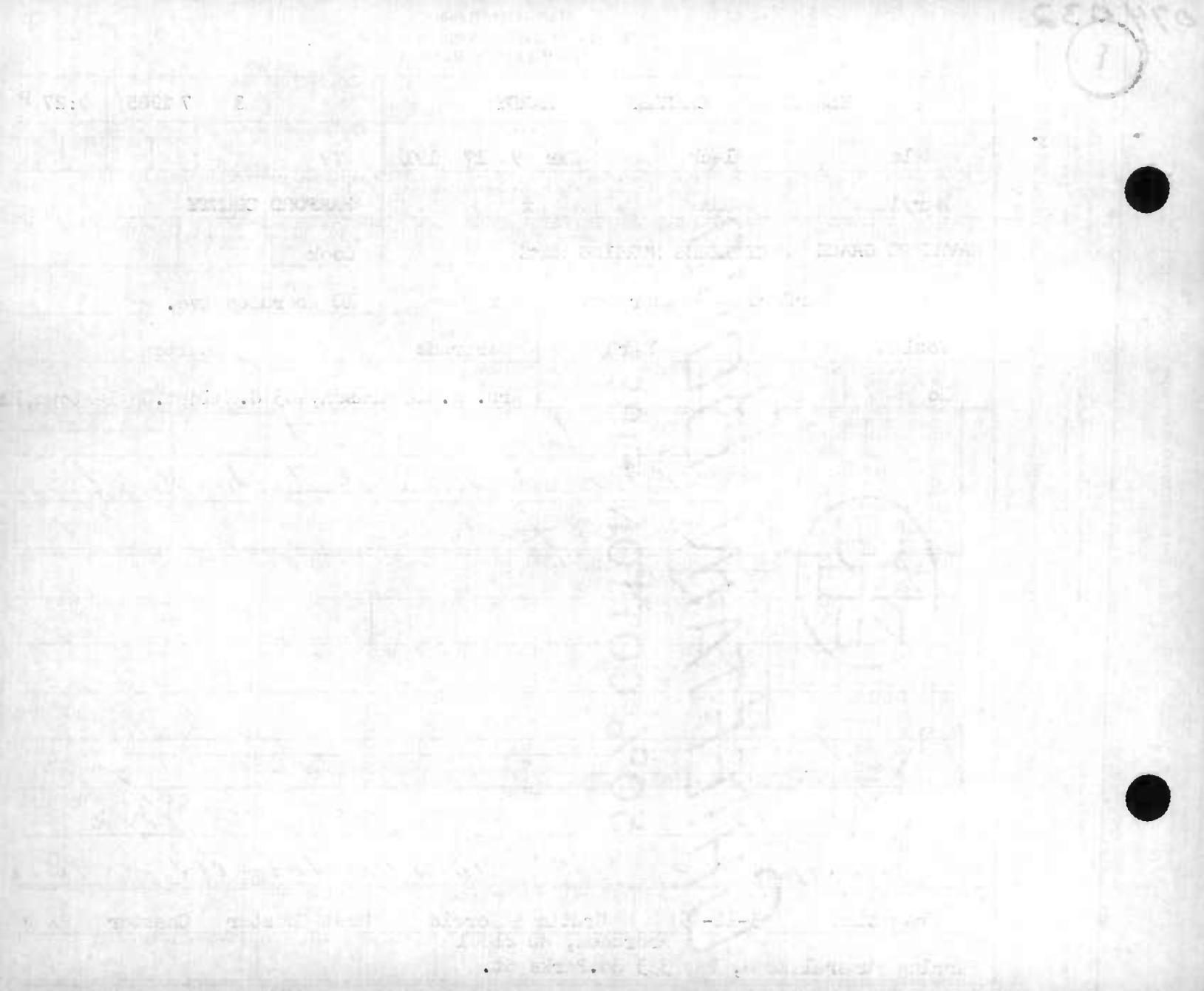
F

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

WEBSITE: If item 21 is marked on item 18, it shows any injury or other traumatic event the medical examiner should be notified of prior to burial.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 5 0 8 6 2 3						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
ELWOOD			CHARLES	CHARLES	HARDY	3 7 1985			3	7	1985	9:27 P M						
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			Black			MONTH MAX 9 DAY 17 YEAR 1911			79			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH						
Maryland			USA						HARFORD COUNTY			HAVRE DE GRACE						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)								12b. KIND OF BUSINESS OR INDUSTRY						
CITIZENS NURSING HOME				Cook														
13a. STATE MD				13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 10 Aberdeen Ave. 21001							
14. FATHER'S NAME FIRST Josiah				MIDDLE		LAST Hardy		15. MOTHER'S MAIDEN NAME FIRST Gertrude			MIDDLE		LAST Moulton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS Mrs. M. Richardson, 403 S. Main St. Doylestown, PA										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) Advanced chronic obstruction lung disease						
{ DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																		
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.												22b. DATE SIGNED 3/18/2008						
22c. SIGNATURE Dr. B. Tarr				DEGREE														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tarr Funeral Home, PA				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 3-11-85			23c. NAME OF CEMETERY OR CREMATORIAL Cratin & Ferris			23d. LOCATION CITY OR TOWN West Chester			COUNTY Chester	STATE PA				
24. FUNERAL DIRECTOR NAME Tarr Funeral Home, PA, 333 So. Parke St.				ADDRESS			25a. DATE REC'D. BY REGISTRAR MAR 13 1985			25b. REGISTRAR'S SIGNATURE								



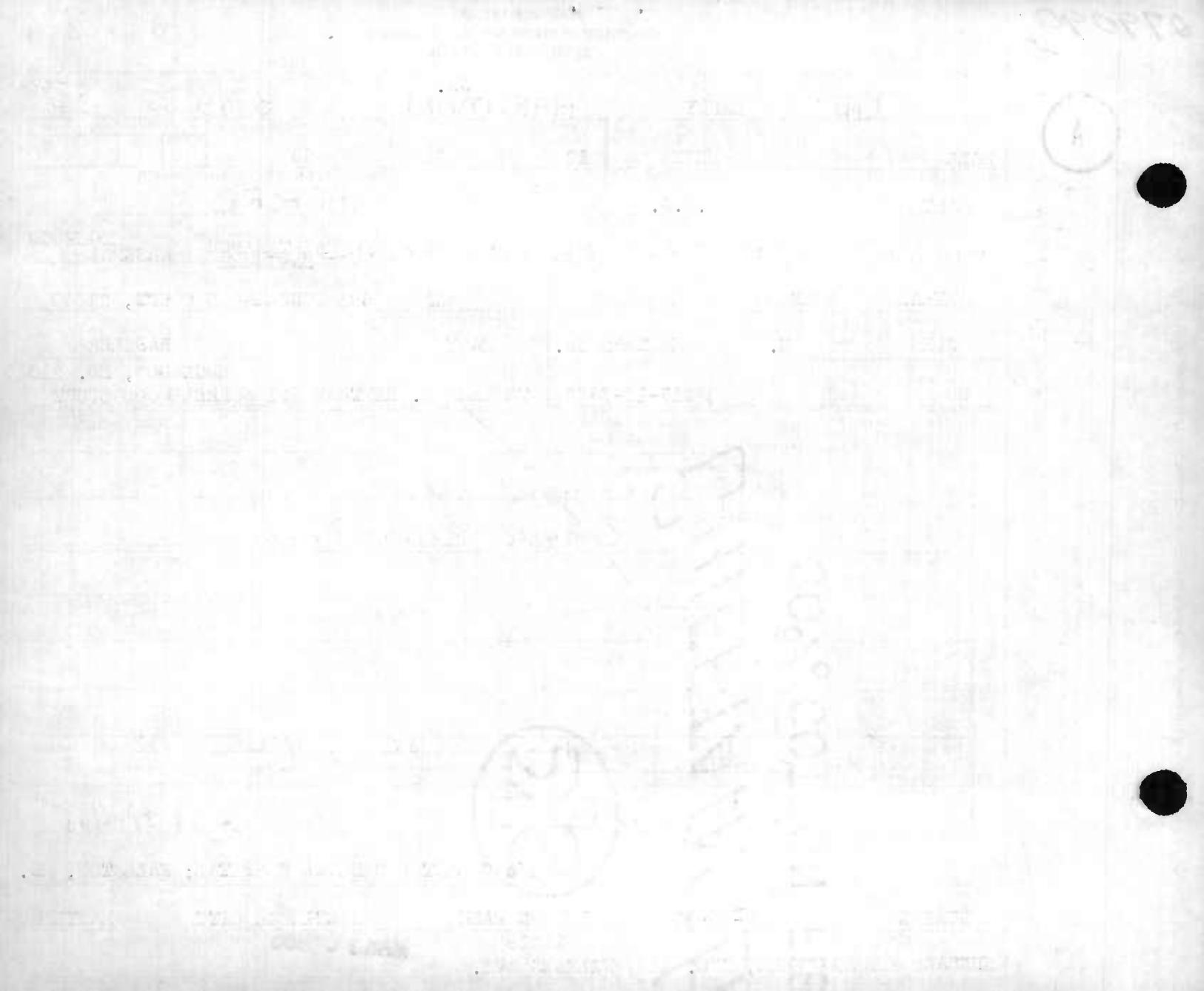
079090
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										3 19 08624						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		JR.		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
JOHN				HENRY				HARTMAN				3 19 85				8:56 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		WHITE		MONTH 12 DAY 24 YEAR 21				63				YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH								
MARYLAND		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				HARFORD								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY						
FALSTON		FALLSTON GENERAL HOSPITAL				MAINTENANCE ENGINEER				EDGEWOOD ARSENAL						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS / ZIP CODE						
MARYLAND		HARFORD		EDGEWOOD		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				601 SORRELLWOOD COURT, 21040						
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME										
JOHN		H.		HARTMAN SR.		FIRST MARY				LAST BASSLER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS				EDGEGOOD, MD. 21040				
NO		217-12-7472		THERESA L. HARTMAN				601 SORRELLWOOD COURT								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A SYSTEMIC DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (c) CARDIAC ARREST																
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 3/12 1985 to 3/12 1985, that (I) (we) last saw the deceased alive on 3/17 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED						
W.S. May 1985										3/12/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS														
		c/o FALLSTON GENERAL HOSPITAL; FALLSTON, MD.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE				
BURIAL		03-16-85		LOUDON PARK				BALTIMORE CITY		MARYLAND		MARYLAND				
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
HUBBARD FUNERAL HOME, INC.		4107 WILKENS AVE.				MAR 13 1985										



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

8625

093089

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 1 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1A. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Pearl	MIDDLE Boyer	LAST HARTZELL	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH 3	DAY 31	YEAR 1985	2b. HOUR 1p M
SEX F	4. RACE W	5. DATE OF BIRTH MONTH Sept.	DAY 5	YEAR 1912	6. AGE (IN YEARS (LAST BIRTHDAY) 72	IF UNDER 1 YR MONTHS YRS.	IF UNDER 24 HRS. DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Upper Salford, Pa.			7b. CITIZEN OF WHAT COUNTRY? USA			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD		
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) Pt 1			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress			12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. STATE Md	13b. COUNTY Baltimore	13c. CITY OR TOWN Fallston	13d. INSIDE CITY LIMITS? YES			13e. STREET ADDRESS 7305 KIRKLEY RD			MD	
14. FATHER'S NAME FIRST Albert			MIDDLE B.	LAST Smith	15. MOTHER'S MAIDEN NAME FIRST Lillian			LAST Boyer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. ---			17. INFORMANT Ronald Hartzell, 3469 Albantowne Way,			ADDRESS Edgewood, Md. 21040	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8199 IMMEDIATE CAUSE (a) MULTIPLE TRAUMA Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF Car accident (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Luis E. Renfro, M.D. <i>Luis E. Renfro</i> TITLE (SPECIFY) EXAMINER'S NAME / (TYPE OR PRINT) Luis E. Renfro										DATE SIGNED 3-31-85
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 5, 1985			23c. NAME OF CEMETERY OR CREMATORIAL Old Goshenhoppen Cem.			23d. LOCATION CITY OR TOWN Upper Salford-Montgomery, Pa.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009			ADDRESS			25a. DATE RECEIVED BY MEDICAL EXAMINER APR 3 1985			25b. MEDICAL EXAMINER'S SIGNATURE Luis E. Renfro	

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82



ONLINE LIBRARY OF THE UNIVERSITY OF TORONTO LIBRARIES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the death certificate until the burial/transit permit is issued.

A

IMPORTANT: If item 18 is marked with a checkmark, the medical examiner must be notified.

BP _____

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

85 08626

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Cordelius A. Hathaway						March	9	1985		6:05 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
M		B		MONTH	DAY	YEAR	66		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Harford			MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Harve de Grace		Harford Memorial Hospital		Retired						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Md.		Harford		Havre DeGrace		YES <input checked="" type="checkbox"/>		509 Alliance St. 21078		
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST			
Elmer			Hathaway	Pearl			Adams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No		220-07-2071		Alvin Hathaway		same as above				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										
SEPTIC SHOCK										
DUE TO, OR AS A CONSEQUENCE OF (b) PERITONITIS										
DUE TO, OR AS A CONSEQUENCE OF (c) DIVERTICULAR BOWEL DISEASE										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Acute Renal Failure										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 21/14/85 to 31/9/85, that (I) (we) last saw the deceased alive on 21/9/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Dante Monakil		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/19/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dante Monakil		22e. ADDRESS 622 S. Union Ave. Havre de Grace Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 3/14/85		23c. NAME OF CEMETERY OR CREMATORIAL St. James Cemetery		23d. LOCATION CITY OR TOWN Havre de Grace Harford Md.				
24. FUNERAL DIRECTOR NAME Arnold Beard 353 Fountain St. Havre DeGrace, Md.		25a. DATE REC'D. BY REGISTRAR MAR 12 1985		25b. REGISTRAR'S SIGNATURE John Leidman, R.N.						

卷之三

1070

1945-52 *Domestic*

1

www.silvano.it

086041

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM 3. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 08621		
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3-21 1985 2b. HOUR 9 52 9 AM											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST					
Calvin NMN Hawkins														
2. SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	7 IF UNDER 1 YR.	8 IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.					
M	B	7 1 33	51 yrs.											
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									8c. DATE PRONOUNCED DEAD MONTH DAY YEAR 3-21 1985 2d. HOUR 9 52 9 AM		
Hayre De Grace			USA									9. BALTIMORE CITY OR COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Hayre De Grace			Harford Memorial Hospital									Disabled		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 564 Girard St. 21078		
MD			Harford			Havre De Grace								
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST					
James						Frances			Skinner					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>			18b. SOCIAL SECURITY NO. 212-32-4469									17. INFORMANT Ethel Hawkins same as above		
Yes Korean War														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Coronary artery disease Coronary Heart Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.														
(b)			ASUVD. - COPD.											
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		
22a. I certify that I took charge of the remains described above, held an			Autopsy <input type="checkbox"/>			Inspection <input checked="" type="checkbox"/>			Inquiry <input type="checkbox"/>			and in my opinion		
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE Luis E. Ronjel			TITLE (SPECIFY) M.D. Deputy									MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Ronjel, MD			ADDRESS 464 Alliance St. Havre De Grace, MD									DATE SIGNED 3-22-85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3/27/85			23c. NAME OF CEMETERY OR CREMATORIAL St. James Cemetery			23d. LOCATION CITY OR TOWN Havre De Grace			COUNTY Harford		
24. FUNERAL DIRECTOR NAME Arnold Beard 353 Fountain St. Havre De Grace, Md.			25a. DATE REC'D. BY REGISTRAR MAR 26 1985									25b. REGISTRAR'S SIGNATURE Julia Davidson		
ADDRESS														

110083

RECEIVED

RECEIVED

RECEIVED

RECEIVED BY POST OFFICE

RECEIVED

RECEIVED



RECEIVED BY POST OFFICE

RECEIVED BY POST OFFICE

RECEIVED BY POST OFFICE

RECEIVED BY POST OFFICE

086026

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 6 2 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Joseph Herman</i>				FIRST <i>W. G.</i>	MIDDLE <i>XXIX</i>	LAST <i>Herman</i>	2a. DATE OF DEATH MONTH <i>3</i>	MONTH <i>1985</i>	DAY <i>08</i>	YEAR <i>0837</i>	2b. HOUR <i>M</i>
1c. SEX <i>Male</i>	1d. RACE <i>White</i>	1e. DATE OF BIRTH MONTH <i>9</i>	DAY <i>07</i>	YEAR <i>08</i>	1f. AGE (IN YEARS LAST BIRTHDAY) <i>75</i>	1g. UNDER 1 YEAR <i>0</i>	1h. UNDER 24 HRS <i>0</i>				
1i. BIRTHPLACE <i>PA</i>	1j. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	1k. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1l. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD CO.</i>							
1o. CITY OR TOWN OF DEATH <i>Fallston, Md.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) <i>Fallston Gen Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired Steelworker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Steel Co.</i>			
13a. STATE <i>Md.</i>	13b. COUNTY <i>ECI</i>	13c. CITY OR TOWN <i>North East</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>287 Rolling Ave.</i>		ZIP CODE <i>21901</i>					
14. FATHER'S NAME FIRST <i>Grant</i>		MIDDLE <i></i>	LAST <i>Harman</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Elizabeth</i>		MIDDLE <i></i>	LAST <i>GATLEY</i>				
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. <i>176 07084</i>	17. INFORMANT <i>Laura Harman</i>		18. ADDRESS <i>287 Rolling Ave.</i>							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Conc. Renal failure</i>											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASD</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22b. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>2/24</i> 19 <i>85</i> to <i>3/17</i> 19 <i>85</i> that (I) (we) last saw the deceased alive on <i>3/19</i> 19 <i>85</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.											
22c. SIGNATURE <i>J. Douglas Abbott</i> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>											
22d. DATE SIGNED <i>3/19/85</i>											
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Douglas Abbott</i>		22f. ADDRESS <i>615 S. Union Ave. Havre de Grace</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <i>3-23-85</i>	23c. NAME OF CEMETERY OR CREMATORIAL North East Meth. Cem., North East Cecil Md.			23d. LOCATION CITY OR TOWN North East		COUNTY Cecil	STATE Md.		
24. FUNERAL DIRECTOR <i>W. Crouch Funeral Home</i>		25a. DATE BY REGISTRAR <i>MAR 26 1985</i>			25b. REGISTRAR'S SIGNATURE <i>W. Crouch Funeral Home</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Please do this.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from the burial permit. Then please remove carbon copies (Pages 1 and 2) and file within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows injury or other traumatic event, the medical examiner will be notified or must be notified of such.

060030

077052
15
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 08629

1- STATE REGISTRAR			2a DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR												2b HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR		2b HOUR					
Ruth			MacLean			Hrubesh			2a DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR		2b HOUR								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR			
F		W		8 6 20			64 YRS.							3-11 1985		6:30P			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
MD			USA			8						Harford							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Abingdon			902 A Long Bar Harbor Rd.												Housewife			--	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			21009				
MD			Harford			Abingdon						902 A Long Bar Harbor Rd.							
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST			Hutchinson				
Hall			--			Calder			Mary			--							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. --			17. INFORMANT			ADDRESS			Edgewood, Md. 21040							
			217-16-7992			Mrs. Sandra L. Truesdale, 610 Holly Ave,													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASCVD - Coronary Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) <i>Off Hypertension -</i> DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?				
															YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Luis E. Renjel</i>																			
TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER																			
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS																
Luis E. Renjel, M.D.			464 Alliance St. HavreDeGrace, MD																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE							
Burial			Mar. 15, 1985			Bel Air Memorial Gardens, Bel Air			Harford			Md.							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Howard K. McComas III, Abingdon, Md. 21009						MAR 14 1985			Lie. Davidson-Pandell										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

retdined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified or

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8508630	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Otto			Huber Jr.			3 14 1985			10:00 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		7 20 1909		75 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		
Baltimore, Md.		U. S. A.				Harford Co.			Street, Md.		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland 13b. COUNTY Harford 13c. CITY OR TOWN Street										12b. KIND OF BUSINESS OR INDUSTRY Iron Worker	
14. FATHER'S NAME FIRST Otto MIDDLE Huber LAST										13a. STREET ADDRESS 1355 Quaker Church Rd., 21154	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			1355 Quaker Church Rd.				
no		219-01-3815		Mr. Otto A. Huber, Street, Md. 21154							
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 76 minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)										3 days	
DUE TO, OR AS A CONSEQUENCE OF (c)										Ca (Esophagus) metastasis 1 year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 3-11-1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. DATE SIGNED 3/15/85	
22b. SIGNATURE Hector L. Fucciano MD.										22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 1200 N. Point Rd								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 3-16-1985		23c. NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gar.			23d. LOCATION CITY OR TOWN Bel Air COUNTY Harford STATE Md.			
24. FUNERAL DIRECTOR NAME E.F. Lassahn, 11750 Belair Rd. Kingsville, Md. 21087										25a. DATE REC'D. BY REGISTRAR MAR 18 1985	
										25b. REGISTRAR'S SIGNATURE Julia T. Wilson - Pendle	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3, RETAIN PAGE 5 WITH FORM FM-3, AND RETURN PAGE 5 WITH FORM FM-3 TO THE CHIEF MEDICAL EXAMINER. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1A AND 2 SHOULD BE KEPT WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												08631	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	Margaret	MIDDLE	Anna	LAST	James	2a. DATE KNOWN OF DEATH ESTIMATED			2b. HOUR	
MARGARET ANNA							JAMES	<input type="checkbox"/> 310 19 85			pm		
1. SEX		4 RACE	F	W	5. DATE OF BIRTH MONTH DAY YEAR	9 19 29	6. AGE (IN YEARS LAST BIRTHDAY)	55 YRS.	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		USA			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. DATE PRONOUNCED DEAD		2d. HOUR		
8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		310 19 85		30		310 19 85		30			
11. CITY OR TOWN OF DEATH			FALLSTON			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
FALLSTON			General			Housewife			21050			—	
13a. STATE			Md			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			2205 Gregory Drive Forest Hill, Md.	
13b. COUNTY			2000 Forest Hill			13f. CITY OR TOWN			2205			Forest Hill, Md.	
14. FATHER'S NAME			FIRST	Charles	MIDDLE	Herbert	LAST	Wells	15. MOTHER'S MAIDEN NAME			Craig	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			no			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
			—			179-24-2439			Harry C. James, 2205 Gregory Drive 21050			Hospital Record, Forest Hill, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?	
19c. DATE OF OPERATION			19d. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			21d. LOCATION STREET		20. AUTOPSY?		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. TITLE (SPECIFY) ACTUAL SIGNATURE <i>Luis E. Renjel</i> M.D. Deputy MEDICAL EXAMINER			22c. DATE SIGNED 3-10-85			STATE				
23a. EXAMINER'S NAME (TYPE OR PRINT)			23b. ADDRESS 464 Allaire St. Newark, Del. 19713			23c. NAME OF CEMETERY OR CREMATORIAL GARDENS, BROOME			23d. LOCATION CITY OR TOWN			23e. COUNTY	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Mar. 14, 1985			23c. NAME OF CEMETERY OR CREMATORIAL GLENWOOD MEMORIAL GARDENS, BROOME			23d. LOCATION CITY OR TOWN			23e. STATE	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR MAR 12 1985			25b. REGISTRAR'S SIGNATURE <i>Howard K. McComas III</i>			Delaware	
Howard K. McComas III, Abingdon, Md. 21009													

